PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
For osteoporosis therapy: Teriparatide (including Forteo and its biosimilar(s))

Please fax form to: 1-866-840-1509

Please note that the patient **AND** physician must complete this form. **All fields are mandatory and must be completed. Incomplete forms may result in your application being declined.** Please retain a copy of this form for your records.

Instructions:

1. **PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to **1-866-840-1509**.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

A. Information to be Completed by Patient

Employee or Insured's Name	Drug Card Number __ __ - __ __ __ __ __ __ - __ __ __ __ __ __ __ __ __ __ - __ __	
Patient's Name	Patient's Date of Birth (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	Relationship to Employee/Insured ❑Employee ❑Spouse ❑Dependent

Please allow two business days for a response once all information is received and complete.
Notification of the results of this request will occur Monday to Friday between 9 am and 4 pm Eastern Time.

Please provide contact information and indicate **ONE** method of preferred contact for notification of the results:

❑ E-mail	❑ Call me (and leave a message if I'm not there)	❑ Fax me at:
❑ Contact my pharmacy: Pharmacy Name		Pharmacy Phone Number

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN _____

Date: (DD/MMM/YYYY): __ __ / __ __ __ / __ __ __ __

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B. Information to be Completed by Prescribing Physician

Drug Name	Strength	Dose
Teriparatide		

Teriparatide **will be eligible for reimbursement only if the patient satisfies the conditions listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program**. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If "None of the above criteria" is indicated, the patient will not be eligible for reimbursement. **For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.**

Eligibility Criteria

Please indicate if the patient satisfies the following criteria:

Initial Criteria – New Starts:

- ❑ Postmenopausal women with severe osteoporosis (102447009)
  - ❑ The patient
    - ❑ Is ambulatory; **AND**
    - ❑ Has normal or clinically nonsignificant abnormal laboratory values prior to start of therapy, as follows:
      - ❑ Serum calcium, PTH(1-84), and urine calcium must be within normal limits; **AND**
      - ❑ 25-hydroxyvitamin D must be between the lower limit of normal and 3 times the upper limit of normal

    AND
    - ❑ Has a bone mineral density (BMD) T-score measured at the hip, femoral neck or lumbar spine less than or equal to -2.5; **AND**
    - ❑ Has shown an inadequate response to antiresorptive therapy (e.g. alendronate, risedronate, zoledronic acid, denosumab), defined by <u>one</u> of the following:
      - ❑ A new fragility fracture following continued treatment with antiresorptive therapy for at least 12 months; **OR**
      - ❑ A significant decrease in BMD, less than the T-score observed during pretreatment in menopausal women with an history of osteoporotic fractures, despite continued taking of the antiresorptive therapy for at least 24 months.

    AND
    - ❑ If requesting Forteo, is intolerant to or had a confirmed adverse event with a teriparatide biosimilar

    AND
  - ❑ Duration of teriparatide therapy will be limited to maximum of 24 months, lifetime

- ❑ Primary or hypogonadal severe osteoporosis in men (T990000040)
  - ❑ The patient
    - ❑ Is ambulatory; **AND**
    - ❑ Is 30-85 years of age; **AND**
    - ❑ Meets <u>one</u> of the following criteria:
      - ❑ Has a history of an osteoporotic vertebral or hip fracture; **OR**
      - ❑ Meets <u>both</u> of the following criteria:
        - ❑ Has a pre-treatment T-score less than or equal to -2.5 or member has osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1) with a high pre-treatment FRAX fracture probability (i.e., 10-year major osteoporotic fracture risk ≥ 20% or hip fracture risk ≥ 3%); **AND**
        - ❑ Has had an oral or injectable bisphosphonate trial of at least 1-year duration or there is a contraindication/intolerance to treatment with an oral bisphosphonate

    AND

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Eligibility Criteria
❑ If requesting Forteo, is intolerant to or had a confirmed adverse event with a teriparatide biosimilar **AND** ❑ Duration of teriparatide therapy will be limited to maximum of 24 months, lifetime ❑ Glucocorticoid-induced osteoporosis (T990000041) ❑ The patient ❑ Is ≥21 years of age; **AND** ❑ Has been taking on average 5.0 mg/day prednisone or equivalent for at least 3 months; **AND** ❑ Meets <u>all</u> of the following criteria: ❑ Has had an oral or injectable bisphosphonate trial of at least 1-year duration or there is a contraindication/intolerance to treatment with an oral bisphosphonate; **AND** ❑ Member meets <u>one</u> of the following criteria ❑ Has a history of a fragility fracture (i.e., fracture occurring spontaneously or following minor trauma such as a fall from standing height or less); **OR** ❑ Has a pre-treatment T-score of less than or equal to -2.5; **OR** ❑ Has osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1) with a high pre-treatment FRAX fracture probability (i.e., 10-year major osteoporotic fracture risk ≥ 20% or hip fracture risk ≥ 3%) **AND** ❑ If requesting Forteo, is intolerant to or had a confirmed adverse event with a teriparatide biosimilar **AND** ❑ Duration of teriparatide therapy will be limited to maximum of 24 months, lifetime OR ❑ None of the above applies Relevant additional information _____

Physician Information				
Physician's Name	License Number	Telephone Number		Fax Number
Address		City	Province	Postal Code
Physician's Signature			Date: (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	