



DATE _____

CLIENT _____

PRIOR AUTH QUESTIONNAIRE- FORTEO®

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient _____	ID# _____ DOB _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please check the box if any of the following applies:

<input type="checkbox"/> Prior skeletal radiation	<input type="checkbox"/> Children or young adults with open epiphyses
<input type="checkbox"/> Paget's Disease	<input type="checkbox"/> Unexplained increases in serum alkaline phosphatase
2. Diagnosis:

<input type="checkbox"/> Postmenopausal Osteoporosis in Women
<input type="checkbox"/> Primary or Hypogonadal Osteoporosis in Men
2. What is the patient's current Bone Mineral Density T-Score? _____
3. Does the patient have a history of osteoporotic fractures? Yes No
4. Has the patient failed or demonstrated intolerance to previous osteoporosis therapy (Fosamax, Actonel, Boniva, Reclast, Miacalcin, Evista, Menostar) Yes No
5. What is the dose and frequency requested? _____

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
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Milwaukee, WI 53224

www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906