

# Pharmacy Prior Authorization Form

Last Reviewed: Jan. 10

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

## Boniva IV<sup>®</sup> (ibandronate)

Urgent  Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Boniva 1 mg/mL injection

Dose: \_\_\_\_\_ Start date: \_\_\_\_\_

Place of administration:

Self-administered

Provider's Office

Outpatient Infusion Center Name of center: \_\_\_\_\_

Home Infusion Name of agency: \_\_\_\_\_

Billing options:

Physician buy and bill (J1740)

Preferred Specialty Vendor

Other: \_\_\_\_\_

### Priority Health Precertification Requirements:

**Authorization of Boniva requires:**

- Diagnosis of postmenopausal osteoporosis
- T-score of at least -2.5
- Documented therapeutic trial of Fosamax, Actonel, and Reclast

Diagnosis:

Postmenopausal osteoporosis– ICD code: \_\_\_\_\_

Other: \_\_\_\_\_ – ICD code: \_\_\_\_\_ Please provide rationale for use:

\_\_\_\_\_

Patient's T-score is -2.5 or less: T-score: \_\_\_\_\_

Yes

No – Rationale for use: \_\_\_\_\_

Patient has had a documented therapeutic trial of **all** of the following:

Yes

No – Rationale for use: \_\_\_\_\_

	Dose	Dates	Outcome
<input type="checkbox"/> Fosamax	_____	_____	_____
<input type="checkbox"/> Actonel	_____	_____	_____
<input type="checkbox"/> Reclast	_____	_____	_____

*Note: Reclast requires step therapy with Fosamax and Actonel first*

\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*  
**Please fax this request to: (877)974-4411 toll free or (616)942-8206**  
**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**