PriorityHealth

Pharmacy
PRIOR AUTHORIZATION FORM

Last Reviewed: January 2012
Last Updated: January 2012

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

This from applies to: ☒ **Commercial Plan** ☒ **Medicaid Plan** ☐ **Medicare Plan**

Boniva IV® (ibandronate)

☐ **URGENT** (life threatening)

☐ **Non-Urgent** (standard review)

A claim involving "urgent care" applies when then standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

________________________________ ____________________
Provider Signature Date

PRODUCT INFORMATION

☐ Boniva 1 mg/mL Solution for Injection **Dose:** ____________________

Start Date:____________________

Note: Authorization, when given, will be for 4 injections (1 injection given every 3 months) annually. Therapies being continued beyond 5 years of combined treatment with Boniva must submit evidence of patient's continued high risk for a future fracture.

BILLING INFORMATION

Place of administration:

☐ Provider's Office
☐ Outpatient Infusion Center
Center Name: ____________________
☐ Home Infusion
Agency Name: ____________________

Billing Options:

☐ Physician buy and bill (J1740)
☐ Preferred Specialty Vendor
☐ Other: ____________________

Request:
☐ New – Complete Section A
☐ Continuation – Complete Section B

PriorityHealth®

PRIORITY HEALTH PRECERTIFICATION REQUIRMENTS
Authorization for Boniva® IV (ibandronate) requires the following information to certify:

Patient must have met the following requirements:
- Diagnosis of postmenopausal osteoporosis
- T-score of -2.5 or less
- Documented therapeutic trial and clinical failure with alendronate (generic Fosamax®), Actonel®, and also with Reclast®

For continuation, patient must have met the following requirements:
- The patient has not received more than 5 years of total treatment with a bisphosphonate or Prolia in a lifetime, unless at high risk for fracture, such as:
  - long-term corticosteroid user, using doses equal to or greater than 7.5 mg prednisone for 3 months or longer, untreated hypogonadism, either spontaneous or surgical premature menopause less than age 45, hyperparathyroidism, hyperthyroidism, chronic liver disease, patient has epilepsy and is currently taking anticonvulsant therapy, documentation of previous fragility fractures

SECTION A – NEW THERAPY

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION
Authorization for Boniva® IV (ibandronate) requires the following information to certify:

A. What is the patient's diagnosis?
a. ☐ postmenopausal osteoporosis ICD code: ________________________
b. ☐ *Other:* ____
Rationale for use: ____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

B. What is the patient's T-score? ___________________

C. Which of the following has the patient had a documented therapeutic trial and clinical failure with (all are required)?

	Dose	Dates	Outcome
☐ alendronate (generic Fosamax®)	______________	_____________	__________________________
☐ Actonel®	______________	_____________	__________________________
☐ Reclast® (step therapy required)	______________	_____________	__________________________

☐ Not all medications above have been tried
Rationale for use: ____

D. How many total years of therapy has the patient received oral or intravenous bisphosphonate or Prolia therapy?

________ years, ________ months

PriorityHealth

SECTION B – CONTINUATION

to be completed for patient's in which Boniva® (ibandronate) was previously authorized by Priority Health

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for continuation of Boniva® IV (ibandronate) requires the following information to certify:

E. What is the patient's diagnosis?

a. ☐ postmenopausal osteoporosis ICD code: ________________________

b. ☐ *Other:* ____

Rationale for use: ____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

F. How many total years of therapy has the patient received oral or intravenous bisphosphonate or Prolia therapy?

________ years, ________ months

G. Which of the following conditions place the patient at continued high risk for a future fracture?

☐ long-term corticosteroid use; doses equal to or greater than 7.5 mg prednisone daily for 3 months or longer

☐ **untreated** hypogonadism; either spontaneous or surgical premature menopause less than age 45

☐ hyperparathyroidism

☐ hyperthyroidism

☐ chronic liver disease

☐ patient has epilepsy and is currently taking anticonvulsant therapy

☐ documentation of previous fragility fractures

☐ Other risk factor: ____

*** 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