

# Pharmacy

## PRIOR AUTHORIZATION FORM

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** (life threatening)

**Non-Urgent** (standard review)

A claim involving "urgent care" applies when the 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: Ibandronate sodium is available in oral and intravenous forms. National Government Services will consider the intravenous form to be "reasonable and necessary" only for patients for whom biphosphonate therapy including oral ibandronate sodium is medically necessary and who cannot tolerate oral therapy. Documentation must show that the patient cannot tolerate oral biphosphonates or that they are otherwise medically contraindicated.

### 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: \_\_\_\_\_

**PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS**

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

**Patient must have met the following requirements:**

- Diagnosis of postmenopausal osteoporosis, bone metastasis, osteoporosis due to complication of transplant, or hypercalcemia of malignancy, Paget's disease, corticosteroid-induced osteoporosis, or osteopenia with documented primary or secondary diagnosis
- Documented therapeutic trial and clinical failure with one oral bisphosphonate (e.g. alendronate, Actonel, Boniva), unless contraindicated.

**PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION**

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

**A. What is the patient's diagnosis?**

- |    |                          |   |                         |
|----|--------------------------|---|-------------------------|
| a. | <input type="checkbox"/> | postmenopausal osteoporosis                                 | ICD code: _____         |
| b. | <input type="checkbox"/> | bone metastasis   | ICD code: _____         |
| c. | <input type="checkbox"/> | osteoporosis due to complication of transplant              | ICD code: _____         |
| d. | <input type="checkbox"/> | hypercalcemia of malignancy                                 | ICD code: _____         |
| e. | <input type="checkbox"/> | Paget's disease   | ICD code: _____         |
| f. | <input type="checkbox"/> | Corticosteroid-induced osteoporosis                         | ICD code: _____         |
| g. | <input type="checkbox"/> | Osteopenia (with documented primary or secondary diagnosis) |                         |
|    | <input type="checkbox"/> | disorder of bone and cartilage                              | ICD code: <u>733.90</u> |
|    | <input type="checkbox"/> | postablative ovarian failure                                | ICD code: <u>256.2</u>  |
|    | <input type="checkbox"/> | premature menopause   | ICD code: <u>256.31</u> |
|    | <input type="checkbox"/> | symptomatic menopausal or female climacteric states         | ICD code: <u>627.2</u>  |
|    | <input type="checkbox"/> | asymptomatic postmenopausal status (natural, age-related)   | ICD code: <u>V49.81</u> |
| h. | <input type="checkbox"/> | Other: _____<br>Rationale for use: _____                    |                         |

**B. Which of the following oral bisphosphonates has the patient had a documented therapeutic trial and clinical failure with?**

	Dose	Dates	Outcome
<input type="checkbox"/> alendronate (generic Fosamax)	_____	_____	_____
<input type="checkbox"/> Actonel	_____	_____	_____
<input type="checkbox"/> Atelvia	_____	_____	_____
<input type="checkbox"/> Boniva	_____	_____	_____
 <input type="checkbox"/> None of the above, oral bisphosphonates are contraindicated for this patient.			

**PRIORITY MEDICARE PLANS**

**Note:** Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

LCD L25820 (A46087) 10-17-2011

\*\*\* 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**