maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST
Boniva IV

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Treatment of osteoporosis in postmenopausal patients – **please answer questions 2 – 12**
   - ☐ Prevention of osteoporosis
   - ☐ All other indications (Please specify): _____
2. ☐ Yes ☐ No Has the patient had a T-score (current or at any time in the past) at or below -2.5 at the lumbar spine, femoral neck, total hip and/or 33% (one-third) radius (wrist)?
3. ☐ Yes ☐ No Does the patient have low bone mass (T-score [current or at any time in the past] between -1.0 and -2.5 at the lumbar spine, femoral neck, total hip and/or 33% [one-third] radius [wrist]) and the physician determines that the patient is at high risk for fracture?
4. ☐ Yes ☐ No Has the patient had an osteoporotic fracture or a fragility fracture?
5. ☐ Yes ☐ No Has the patient tried one oral bisphosphonate or oral bisphosphonate-containing product and had an inadequate response after a trial duration of 12-months as determined by the prescribing physician (for example, ongoing and significant loss of bone mineral density [BMD], lack of BMD increase)?
6. ☐ Yes ☐ No Has the patient had an osteoporotic fracture or a fragility fracture while receiving oral bisphosphonate therapy?
7. ☐ Yes ☐ No Has the patient experienced intolerability to an oral bisphosphonate (for example, severe GI-related adverse effects)?
8. ☐ Yes ☐ No Is the patient unable to take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing?
9. ☐ Yes ☐ No Is the patient unable to take an oral bisphosphonate because the patient cannot remain in an upright position after taking an oral bisphophonate?
10. ☐ Yes ☐ No Is the patient unable to take an oral bisphosphonate because the patient has a pre-existing GI medical condition in which IV bisphosphonate therapy may be warranted

If you have any questions, call: 800-753-2851

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(for example, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia])?

11. ☐ Yes ☐ No Has the patient tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast)?

12. ☐ Yes ☐ No Except for calcium and vitamin D, will the requested medication be used in combination with other medications for osteoporosis?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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