



Send completed form to:
 Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Boniva

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. Which drug is being prescribed? Boniva, Dose: _____ Frequency: _____
 Other _____
2. What is the diagnosis?
 Osteoporosis in postmenopausal woman
 Other _____
3. What is the T-score? _____ (**Fax copy of results**)
4. Is the patient at least 50 years of age with a fragility fracture? Yes No
5. Has the patient had a trial of oral bisphosphate therapy (e.g., Actonel, Boniva Tablets, Didronel Tablets, Fosamax, Skelid)? **If no, skip to # 7* Yes No
6. Was the patient adherent to prescribed therapies? Yes No
7. Does the patient have any of the following contraindications or intolerance to oral bisphosphonate therapy? Yes No
 - Renal function impairment
 - Esophageal abnormality that delays emptying such as stricture or achalasia
 - Active upper gastrointestinal problem (eg, dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers)
 - Inability to stand or sit upright for at least 30 to 60 minutes
 - Inability to take at least 30 to 60 minutes before first food, drink, or medication of the day
8. Has the patient had a trial of Reclast? Yes No
9. Has the patient had intolerance to Reclast therapy? Yes No
10. Has it been 12 months since Reclast was last prescribed? Yes No
11. Is the patient currently on or will be receiving supplemental calcium plus vitamin D? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

12. Does the patient have creatinine clearance (CrCl) greater than or equal to 30 mL/min and normal serum calcium level? Yes No

****NOTE: We can NOT make a decision without a copy of lab results - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature Date (mm/dd/yy)

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