

Physician Forteo/Boniva Injection Coverage Determination Form

Fax non-urgent requests to PerformRx Pharmacy Services at **866-369-6038** or urgent requests to **866-533-5491**. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **866-533-5490**. *Form must be completed for processing.*



Patient's Name: _____
 Address: _____
 City: _____ State: _____
 Phone #: _____ Weight: _____ lbs = _____ Kg

Plan ID#: _____
 Apt # or Suite #: _____
 Zip Code: _____
 Birth Date: _____

Physician's Name: _____
 Address: _____
 City: _____ State: _____
 Contact Person: _____ Phone #: _____ Fax #: _____

NPI #: _____
 Apt # or Suite #: _____
 Zip Code: _____

Physician's Signature: _____

Attach Additional Information if Necessary

Drug to be administered from (on): _____ to _____ Or was administered on: _____ replacement for physician's office.
 Dose: _____ Sig: _____
 Diagnosis: _____ ICD-9 Diagnosis Code: _____
 T-score: _____ Date: _____ Paget's Disease: Y or N
 Most recent fracture(s): Date: _____ Site(s): _____

Please indicate the applicable process:

- The medication will be acquired by the physicians' office, hospital or long-term care facility and billed directly to the plan by that physician or facility.
- A local, long term care, or specialty pharmacy will provide the medication and bill the plan.

Deliver to:

Physician's Office Patient's Home Patient filling at local Pharmacy (Name) _____ Phone: _____

For Coverage Determination to treat Osteoporosis additional information is needed to proceed with review. Prior to receiving approval for this specialty medication therapy, the patient must have a documented medical reason to be unable to take preferred medications (see the table below of therapeutic alternatives). Please identify the therapies attempted and document the dose, start date, end date and reasons for discontinuation (e.g. intolerance, hypersensitivity, other medical reasons, etc.).

<input checked="" type="checkbox"/>	Drug	Dose	Start Date	End Date	Comments
<input type="checkbox"/>	Calcium w/Vitamin D				
<input type="checkbox"/>	HRT (for women)				
<input type="checkbox"/>	Raloxifene (Evista®) (for women)				
<input type="checkbox"/>	Alendronate (Fosamax®) or Risedronate (Actonel®)				
<input type="checkbox"/>	Calcitonin (Miacalcin®)				
<input type="checkbox"/>	Other ()				

Additional Comments (please attach additional information if needed): _____

