

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