

Physician Prior Authorization Request Form for Forteo[®], Reclast[®], or Boniva[®] Injection

Fax to PerformRx Pharmacy Services at **215-937-5018**, or to speak to a representative call **800-588-6767**. Form must be completed for processing.

Patient's Name: _____

Member ID#: _____

Address: _____

Apt # or Suite #: _____

City: _____ State: _____

Zip Code: _____

Phone #: _____ Weight: _____ lbs = _____ Kg

Birth Date: _____

Physician's Name: _____

NPI #: _____

Address: _____

Apt # or Suite #: _____

City: _____ State: _____

Zip Code: _____

Contact Person: _____ Phone #: _____ Fax #: _____

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): _____

Deliver to:

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

Prior to receiving approval for therapy, the patient must have a documented medical reason to be unable to take formulary medications (see the table below of formulary alternatives). Please identify the therapies attempted and document the dose, start date, end date and reasons for discontinuation (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"/>	Oral Bisphosphonates i.e. Alendronate (Fosamax [®]) or Risedronate (Actonel [®])				
<input type="checkbox"/>	Calcitonin (Miacalcin [®])				
<input type="checkbox"/>	Other ()				

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