



Date _____

Client _____

PRIOR AUTH CRITERIA- BISPHOSPHONATES

M.D. Last Name: _____ M.D. First Name: _____

Physician Phone: _____ Physician Fax: _____

Patient _____ ID# _____ DOB _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please indicate which agent is being requested:

STEP B*

- Actonel

STEP C**

- Actonel with Calcium
- Boniva
- Branded Fosamax
- Fosamax Plus D

***Please note that if member is beginning therapy with a Bisphosphonates, the member's benefit will only cover generic alendronate, unless the member has already tried and failed generic alendronate**

****Please Note that Step C drugs will not be approved unless all Step B drugs have been tried and failed**

2. For Step B Coverage ONLY: Has the patient tried and failed a 30-day trial of generic alendronate? Yes No

3. Please explain the reason for failure or non-trial, and attach notes from the patient's chart as documentation.

4. Is the patient pregnant? Yes No

5. Does the patient have a hypersensitivity to any of the components of Actonel, Actonel with Calcium, Boniva, Fosamax, or Fosamax Plus D? Yes No

6. Does the patient have hypocalcemia or an inability to stand or sit upright for at least 30 minutes (60 minutes for Boniva)? Yes No

7. **Fosamax Only**-Does the patient have any abnormalities of the esophagus that delay esophageal emptying, such as stricture or achalasia? Yes No

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906