



Boniva® (ibandronate) Prior Authorization Request Form

Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-466-9854. For additional information call 314-214-8501 or 800-647-22

Patient Name: _____ Today's Date: ____/____/____
Patient Pharmacy ID: _____ Date of Birth: ____/____/____
(located on bottom right of insurance card)
Requesting Physician: _____ Specialty: _____
(Please print)
Office Contact Person: _____ Phone #: _____
Medication/dose Requested: _____ Fax #: _____

INITIAL REQUEST:

- 1. Gender (circle) Male Female
2. Does the patient have a diagnosis of postmenopausal osteoporosis? YES NO
3. Does the patient have T-score of AT LEAST 2.5 Standard Deviations from the mean (i.e. -2.5 or below)? YES NO
T-score: _____ Date: _____
4. Does the patient have any of the following risk factors for possible fracture? (mark all that apply) YES NO
[] History of osteoporotic fracture? Date of (or) determined date of fracture: _____
[] Other risk factors for fracture
[] Female sex [] Thin or small frame (<70 kg)
[] Age > 60 years [] Family history of osteoporosis (1st degree relative)
[] Estrogen deficiency [] Diet low in calcium - for a long period of time (years)
[] Low testosterone levels (men) [] Physical inactivity
[] Cigarette smoking [] Excessive use of alcohol - only if affects nutrition
[] Medications (corticosteroids, anticonvulsants, or thyroid medications)
5. Has the patient failed previous bisphosphonate therapy? YES NO
Medication(s) tried: _____
Length of trial? _____
6. Is patient taking daily calcium of 1200 mg/day and vitamin D 400-800 IU/day? YES NO
7. Is the patient's serum creatinine <2.3 mg/dl? YES NO
Serum Creatinine: _____ Date: _____
8. Is the patient's Creatinine clearance greater than 30 ml/minute? YES NO
Creatinine clearance: _____ Date: _____

RENEWAL CRITERIA:

- 1. Has it been 3 months since the last dose of Boniva injection? YES NO
Date of last dose: _____
2. Is the patient's serum creatinine <2.3 mg/dl? YES NO
Serum Creatinine: _____ Date: _____
3. Is the patient's Creatinine clearance greater than 30 ml/minute? YES NO
Creatinine clearance: _____ Date: _____

Physician's Signature: _____ Date: ____/____/____

For Mercy Health Plans use only: [] Approved Length of Approval _____
[] Denied Reason for Denial _____
Reviewer's Signature: _____ Date Reviewed: ____/____/____
Override Entered in [] Caremark [] CCMS for _____ - _____ by _____
Office Notified on _____; at _____ am/pm; by _____ spoke to _____