Prior Authorization Request Form for
Oral Bisphosphonates

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________
Address: ______________________ Address: ______________________
______________________ ______________________
Sponsor ID # ______________________ Phone #: ______________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Which medication is requested?	☐ **Binosto** (alendronate 70 mg effervescent tablet) – **Proceed to question 2** ☐ **Fosamax Plus D** (alendronate 70 mg + vitamin D) – **Proceed to question 4** ☐ **All others** – **Proceed to question 5**	
2. *(Binosto request)* **Does the patient have swallowing difficulties and cannot consume 8 ounces (1 cup) of water?**	☐ Yes Proceed to question 3	☐ No Proceed to question 5
3. *(Binosto request)* **Does the patient have a sodium restriction?**	☐ Yes Proceed to question 5	☐ No Sign and date below
4. *(Fosamax Plus D request)* **Can the patient take alendronate and vitamin D as 2 separate tablets?**	☐ Yes Proceed to question 5	☐ No Sign and date below
5. Has the patient experienced significant or intolerable adverse effects from alendronate or ibandronate tablets?	☐ Yes Sign and date below	☐ No Proceed to question 6
6. Does the patient have a contraindication to alendronate or ibandronate tablets?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

______________________ Prescriber Signature ______________ Date

[09 November 2016]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: