

**Physician Forteo®/Boniva® Injection
Coverage Determination Form**

Fax non-urgent requests to PerformRx Pharmacy Services at **866-369-6041**
or urgent requests to **866-533-5497**. 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 **866-369-6037**. *Form must be completed for processing.*



Patient's Name: _____

Plan 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): _____

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): _____