



Boniva® (ibandronate) & Reclast® (zoledronic acid) 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 314-214-8282 or 800-647-2240

Patient Name: Today's Date:
Patient Pharmacy ID: Date of Birth:
Requesting Physician: Specialty:
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... YES NO
4. Does the patient have any of the following risk factors for possible fracture? YES NO
5. Has the patient failed previous bisphosphonate therapy? YES NO
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
8. Is the patient's Creatinine clearance greater than 30 ml/minute? YES NO

RENEWAL CRITERIA:

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

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