

~ **BONE RESORPTION INHIBITORS INJECTABLE** ~
 Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of injectable bone resorption inhibitors. For beneficiaries to receive coverage for these agents, it will be necessary for the prescriber to telephone or complete and fax this form to Catamaran. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name: _____

Phone #: _____

Fax #: _____

Address: _____

Contact Person at Office: _____

Beneficiary:

Name: _____

Medicaid ID #: _____

Date of Birth: _____ Sex: _____

Will this medication be billed through the: **pharmacy benefit** or **medical benefit** (J-code or other code)?
(Please check one)

Administering Provider/Facility if other than Prescriber: (name): _____ NPI #: _____

Pharmacy (if known): _____ Phone: _____ &/or FAX: _____

Drug requested: Boniva IV Forteo Prolia Reclast Xgeva Zoledronic Acid

Dose & frequency: _____

Diagnosis/indication:
 Treatment of postmenopausal osteoporosis Treatment of male osteoporosis

 Paget's Disease Treatment of glucocorticoid induced osteoporosis

 Bone metastases from solid tumors (tumor type: _____)

 Other (Please Explain) _____

Has the member previously tried the following preferred medication?

<i>Drug:</i>	<i>Response:</i>
<input type="checkbox"/> Alendronate Oral	<input type="checkbox"/> side-effect <input type="checkbox"/> treatment failure* dates of use: _____

*Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with the bisphosphonate.

Prescriber comments: _____

Prescriber Signature: _____ **Date of this request:** _____