



Department of Vermont Health Access
 NOB 1 South, 280 State Drive
 Waterbury, Vermont 05671-1010

BONERESORPINHBINJ.3
 FORM#02
 R: 03.16

Agency of Human Services

~Bone Resorption Inhibitors Injectable~ Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the GHS Helpdesk at 1-844-679-5363.

Submit request via: Fax: 1-844-679-5366

Prescribing physician:

Beneficiary:

Name: _____
 Phone#: _____
 Fax#: _____
 Address: _____
 Contact Person at Office: _____

Name: _____
 Medicaid ID#: _____
 Date of Birth: _____ Sex: _____
 Pharmacy Name _____
 Pharmacy Phone: _____ Pharmacy Fax: _____

The following MUST be completed for MEDICAL BENEFIT requests:

- HCPCS J-code or other code: _____
- Administering Provider/Facility: Name _____ NPI# _____ Medicaid ID# _____

Please **check box** if this drug is being provided under the DVHA's 340B Drug program and requires the **UD modifier**

Drug requested: Boniva IV Forteo Ibandronate IV Prolia
 Reclast Xgeva Zoledronic Acid Zometa

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?

Drug :	Response:
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: _____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

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

