

~ **OSSIFICATION ENHANCING INJECTABLE** ~  
 Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of ossification enhancing injectables. For beneficiaries to receive coverage for these agents, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. 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: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_

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

Administering Provider if other than Prescriber: (name): \_\_\_\_\_ NPI #: \_\_\_\_\_

Pharmacy (if known): \_\_\_\_\_ Phone: \_\_\_\_\_ &amp;/or FAX: \_\_\_\_\_

**Drug requested:**  Boniva IV  Forteo  Prolia  Reclast IV

**Dose & frequency:** \_\_\_\_\_

**Diagnosis/indication:**

- Treatment of postmenopausal osteoporosis     Treatment of male osteoporosis  
 Paget's Disease     Treatment of glucocorticoid induced osteoporosis  
 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:**


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**Prescriber Signature:** \_\_\_\_\_

**Date of this request:** \_\_\_\_\_