Physician Prior Authorization Request Form for Forteo®, Reclast®, Prolia®, or Boniva® Injection

Fax to Pharmacy Services at **855-811-9332**, or to speak to a Representative, call **888-602-3741**. *Form must be completed for processing.*

AmeriHealth Caritas District of Columbia

Patient's Name: _____ Patient 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 Requested (name): _____ Dose:_____Sig:_____

Drug to be administered from (on): _____ to _____ Or was administered on: _____

Diagnosis: _____ ICD-9 Diagnosis Code: _____

T-score: _____ Date: _____

Probability within the next ten years of a hip fracture_____ % or major osteoporosis-related fracture_____% (based on US-adapted WHO algorithm)

Osteoporotic fracture(s): Date: _____ Site(s): _____

Deliver to:
☐ Physician's Office ☐ Patient's Home ☐ Patient filling at local Pharmacy (Name) _____ Phone: _____

<u>Prior Therapies</u> (please document any previous therapies (including the name of the medication) that were tried and failed and reason for discontinuation (intolerance, hypersensitivity, other medical reasons, etc.). Please attach any need extra documentation.)

Drug	Dose	Start Date	End Date	Comments
Calcium w/Vitamin D				
<u>Oral Bisphosphonate:</u> Name(s):				
<u>Other(s):</u> Name(s):				

Additional Comments (please attach additional information if needed):

_____

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