PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Boniva IV

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the patient a new start to therapy? If no, please provide start date.

☐ Yes ☐ No

Q2. Please provide ICD code(s) for diagnosis.

Q3. Does the patient have any of the following?

- ☐ Active gastrointestinal bleed
- ☐ Gastrointestinal ulcers
- ☐ Esophageal motility disorder
- ☐ Esophagitis
- ☐ Inability to sit/stand for at least 30 minutes after oral therapy
- ☐ None of the Above

Q4. Has the patient previously tried and failed at least 2 different oral bisphosphonate drugs due to gastrointestinal intolerance?

☐ Yes ☐ No

Q5. Please provide the names of the drugs previously tried and failed.

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Q6. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q7. Provide name and NPI of the billing entity

Q8. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q9. Additional Comments

Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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