

PRIOR AUTHORIZATION REQUEST FORM

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:	Phone.
Group Number:	NPI:	State Lic ID:
Address:	Address:	State Lic 1D.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may estions and sign.	support approval. Please answer the
Q1. Is the patient a new start to therapy? If no, please pro-	vide 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 di intolerance?	fferent oral bisphospho	nate drugs due to gastrointestinal
☐ Yes	□No	
Q5. Please provide the names of the drugs previously tried	d and failed.	



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:
Q6. Who is the ENTITY that will be submitting the CLAIM f Pharmacy Individual prescriber Provider or specialty group Facility Other (please specify)	or the DRUG and seeking reimbursement?
Q7. Provide name and NPI of the billing entity	
Q8. Will the claim for the drug be submitted as a MEDICAL submitting a MEDICAL claim for drug reimbursement, answ	· · · · · · · · · · · · · · · · · · ·
☐ Medical	Pharmacy
Q9. Additional Comments	
Prescriber Signature	Date
□ Expedited/Urgent - By checking this box and signing abov	e, 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.



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.**

	Prescriber Name:
Patient Name:	Supervising Physician:

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document