restat
A Dohmen Company

Date _____

PRIOR AUTHORIZATION CRITERIA-Bisphosphonates-Actonel®

M.D. Last Name: _____ ***M.D. First Name:*** _____

Physician Phone: _____ ***Physician Fax:*** _____

Patient _____ ***ID#*** _____ ***DOB*** _____

****FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL****

1. Does the patient have a hypersensitivity to any of the components of the product? Yes No

2. Does the patient have hypocalcemia or an inability to stand or sit upright for at least 30 minutes? Yes No

3. Has the patient tried and failed a 30-day supply of generic alendronate? Yes No

   a. If Yes, provide dates of trial _____

   b. If No, provide the rationale for non-trial _____

4. Physician Signature or name of person providing answers _____

Physician Comments _____

_____

_____

Send or Fax completed form to:
877-329-7279

Restat
11900 W. Lake Park Dr.
Milwaukee, WI 53224

www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906

 Date 9/1/2010