04/10/2013

Fallon Community Health Plan MassHealth

FCHP (MEDICAID)

Boniva (FCHP)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Fallon Community Health Plan MassHealth at **1-855-762-5204**.
Please contact Fallon Community Health Plan MassHealth at **1-866-643-5126** with questions regarding the fallon community health plan masshealth process.
When conditions are met, we will authorize the coverage of Boniva (FCHP) .

Drug Name (select from list of drugs shown)

Boniva (ibandronate)

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Please circle the appropriate answer for each question.

1. Does the patient have any of the following contraindications: Y N
   Hypersensitivity to Boniva or to any of its components \ Uncorrected hypocalcemia \ Inability to stand or sit for at least 60 minutes if the request is for Boniva tablets
   [If the answer to this question is yes, then no further questions required.]
2. Is the patient a post-menopausal woman who requires treatment Boniva for treatment or prevention of osteoporosis? Y N
   [If the answer to this question is no, then no further questions required.]
3. Has the patient had a trial and failure of or intolerance to Fosamax or Actonel? Y N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature and Date