reliance|rx℠
15 Earhart Drive, Suite 101, Amherst, NY 14221

BONIVA INJECTION AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name	First Name		Today's Date		
Date of Birth:	Sex:	Weight:	Prescriber	Hospital/Clinic	
Home Phone Number ( )	Work Phone Number ( )		Phone Number ( )	Fax Number ( )	
Home Address	City	State Zip	Address	City	State Zip
Payor: ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions	☐ Commercial ☐ Medicaid	☐ Medicare ☐ Self-funded	Notes: Allergies:		
Insurance ID:	Group Number:				

Drug Name: Boniva

☐ New Authorization ☐ Reauthorization*

ICD10 Code: _____

Dose: _____

Frequency: _____

Is the female patient post-menopausal? ☐ Yes ☐ No

AND

Does the patient have a confirmed diagnosis of osteoporosis? ☐ Yes ☐ No

AND

Does the patient have a documented inability to swallow, or an established esophageal diagnosis which prevents oral administration of a bisphosphonate? ☐ Yes ☐ No

AND

Patient's current serum calcium levels submitted. (attached to request) ☐ Yes No

AND

Is the patient's current serum creatinine level and weight submitted for purposes of calculating creatinine clearance? (attached to request) ☐ Yes ☐ No

Pt weight:_____ Date:_____

If medication is being requested for administration by home care:

Does patient have an illness or injury that restricts his/her ability to leave his / her residence except with the aid of supportive devices, such as canes, crutches, wheelchair, walker, special assistance or the assistance of another person; or is leaving the home medically contraindicated? ☐ Yes ☐ No

*For Re-Authorization:

Serum Calcium Level: _____ Date:_____

Serum Creatinine Level: _____ Date:_____

Has patient tolerated and responded well to therapy? ☐ Yes ☐ No