

OPTIMA HEALTH PLAN

OUTPATIENT PHARMACY PRIOR AUTHORIZATION REQUEST FORM*

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff and faxed to 757-552-7429 or 1-877-800-2839. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.*

Drug Name: Boniva® IV (ibandronate intravenous) Code-J1740

- **Boniva®** is indicated for the treatment and prevention of postmenopausal osteoporosis. Bone mineral density increased and incidence of vertebral fractures decreased in postmenopausal women with the administration of **Boniva®**.
- The intravenous formulation is given every 3 months. It has also demonstrated efficacy for the treatment of hypercalcemia of malignancy. **Boniva®** can be considered an alternative agent for the treatment of hypercalcemia associated with malignancy.
- Osteonecrosis, primarily in the jaw, has been reported in patients treated with bisphosphonates. Most reported cases have been in patients treated with bisphosphonates IV.
- **Boniva®** is contraindicated in patients with uncorrected hypocalcemia and patients with hypersensitivity to any of the product ingredients. Use is not recommended in patients with severe renal impairment.

Please complete below

- Patient has tried and failed **Fosamax®** and is intolerant to PO bisphosphonates.

OR

- Patient is unable to take medications by mouth.

OR

- Patient is unable to sit up for the required period for oral dosage forms.

Patient: _____

Member Number: _____

SIGNED _____ **DATE** _____

Physician Name _____ **Phone Number** _____

Fax Number _____

Pharmacy Name _____ **Pharmacy Tel #** _____

(IF AVAILABLE)

* Approved by Pharmacy and Therapeutics Committee June 15, 2006