



This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: [www.express-scripts.com/pa](http://www.express-scripts.com/pa)

Fax completed form to **1-800-357-9577**  
If this an **URGENT** request, please call 1-800-417-8164

**Patient Information**

Patient First Name: \_\_\_\_\_

Patient Last Name: \_\_\_\_\_

Patient ID#: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_

**Prescriber Information**

Prescriber Name: \_\_\_\_\_

Prescriber DEA/NPI (required): \_\_\_\_\_

Prescriber Phone #: \_\_\_\_\_

Prescriber Fax #: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Please indicate which drug and strength is being requested:

- |  |  |
|--|--|
| <input type="checkbox"/> Actonel 5mg Tablet                  | <input type="checkbox"/> Fosamax 5mg Tablet                    |
| <input type="checkbox"/> Actonel 30mg Tablet                 | <input type="checkbox"/> Fosamax 10mg Tablet                   |
| <input type="checkbox"/> Actonel 35mg Tablet                 | <input type="checkbox"/> Fosamax 35mg Tablet                   |
| <input type="checkbox"/> Actonel 150mg Tablet                | <input type="checkbox"/> Fosamax 40mg Tablet                   |
| <input type="checkbox"/> Atelvia 35mg Delayed-Release Tablet | <input type="checkbox"/> Fosamax 70mg Tablet                   |
| <input type="checkbox"/> Boniva 150mg Tablet                 | <input type="checkbox"/> Fosamax 70mg/75ml Solution            |
|  | <input type="checkbox"/> Fosamax Plus D 70mg-2800 units Tablet |
|  | <input type="checkbox"/> Fosamax Plus D 70mg-5600 units Tablet |

Directions for use (i.e. QD, BID, PRN & Qty): \_\_\_\_\_

Please complete the clinical assessment:		
1. Is the patient currently taking the requested medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is the patient taking samples or paying 100% out of pocket for the medication being requested? If no, please indicate: <input type="checkbox"/> Requested medication covered under previous insurance plan <input type="checkbox"/> Started medication in hospital <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has the patient tried alendronate tablets (brand or generic)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Has the patient tried Actonel, Atelvia, Boniva, Fosamax OR Fosamax Plus D tablets?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

5. Does the patient have Paget's disease AND has started therapy with Actonel tablets?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Is the patient an adult who has a gastrostomy tube (G-tube), cannot swallow, or has difficulty swallowing tablets?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Is the patient a child who requires an oral solution?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?**

---



---



---



---



---

Prescriber Signature: _____	Date: _____
Office Contact Name: _____	Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

The document(s) accompanying this transmission may contain confidential health information. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of the documents.