

Drug Coverage Review Request

State of NC Actonel, Actonel with Calcium and Fosamax Plus D - Prior Authorization

35045



SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

PRESCRIBER

MD First Name _____
MD Last Name _____
Address _____
City _____
State _____
Zip Code _____
Phone _____
Fax _____
DEA number (optional) _____

PATIENT

Cardholder's ID# _____
Patient Last Name _____
Patient First Name _____
Date of Birth _____
Address _____
City _____
State _____
Zip Code _____
Phone _____

SECTION A Please answer the following questions

1. Specify the NAME and STRENGTH of the prescribed medication: _____
2. YES NO Is this drug being prescribed for the treatment of Paget's disease?
3. YES NO Has the patient experienced intolerance (that is, sensitivity, drug allergy, or adverse effect) to treatment with a preferred bisphosphonate (generic alendronate or *Boniva*)?

SECTION B Physician signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1 800 837-0959

PLEASE DO NOT FAX WITH A COVER SHEET

Location: Nevada (15) Case Id: 9999999



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