

Bravo Health

Coverage Review / Prior Authorization Request Form
Bisphosphonates (Actonel®, Boniva®, Fosamax® brand)



Patient Information		Prescriber Information	
Member Name:		Prescriber Name:	
Bravo ID #		Prescriber Specialty:	
DOB:		Prescriber Address:	
Address:			
		Office Phone#:	
Home Phone:		Office Fax #:	
		Contact Person:	
Diagnosis and Medication Requested			
Medication Requested (dosage, frequency):		Qty:	
Prescribing Diagnosis:	ICD9 Code	Date Therapy Initiated:	
Clinical Criteria			
Please answer the following questions:			
1. Has the patient has experienced an inadequate response or intolerance to the use of Alendronate tablets (Fosamax®)?			
<input type="checkbox"/> Yes			
<input type="checkbox"/> No*			
*Request will be denied if above diagnosis criteria is not met.			
**<u>Please provide clinical notes supporting intolerance or failed therapy with Alendronate (Fosamax®).</u>			
Additional Comments/Explanation:			
Request for Expedited Review			
<input type="checkbox"/> REQUEST FOR EXPEDITED REVIEW [24 HOURS] BY CHECKING THIS BOX AND SIGNING BELOW, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION			

Prescriber's Signature: _____ Date: _____

Fax back to: 866-464-0709 For info call: 877-813-5595
For additional Prior Authorization forms, go to <http://www.bravohealth.com/providers.aspx>