



Phone: 800-842-2015 Fax: 877-837-5922

PATIENT DATA	Last Name	First Name	Policy Number	Date of Birth	Age
REQUESTING PHYSICIAN DATA	Last Name	First Name	Contact Name	Fax Number ()	
BCBSLA Provider Number		Area of Practice/Specialty	Phone Number ()		
REQUESTED DRUG*					
<input type="checkbox"/> Actonel® <input type="checkbox"/> Actonel® with Calcium <input type="checkbox"/> Atelvia® <input type="checkbox"/> Boniva® tablets <input type="checkbox"/> Fosamax® <input type="checkbox"/> Fosamax® Plus D <input type="checkbox"/> Other					
INDICATION / DIAGNOSIS					
<input type="checkbox"/> Treatment and prevention of postmenopausal osteoporosis <input type="checkbox"/> Treatment of Paget's disease <input type="checkbox"/> Treatment of glucocorticoid-induced osteoporosis					
PAST TREATMENT HISTORY (Check ALL that apply)					
<input type="checkbox"/> alendronate tablets <input type="checkbox"/> Actonel® tablets <input type="checkbox"/> Other _____					
OTHER CLINICAL INFORMATION (Check ALL that apply)					
<input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have an abnormality of the esophagus that delays esophageal emptying (stricture or Achalasia)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient an adult who has a gastrostomy tube (G-tube)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient an adult who cannot swallow or has difficulty swallowing tablets? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient a child who requires an oral solution? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there clinical evidence or patient history that suggests the step 1 medication will be ineffective or cause an adverse reaction to the patient? _____					
PHYSICIAN SIGNATURE			DATE		
_____ Prescribing Physician			_____		
<p>Preferred brand drugs (tier 2) are designated in bold.</p> <p>Note: On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.</p>					

Incomplete forms will not be processed