



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	Name of Place of Treatment	Treatment Ctr Provider #	Phone Number ()	
BILLING DATA	Diagnosis Code(s) (ICD-9): 1) 2)		CPT-4/HCPCS Code	Other Codes	

DRUG INFORMATION

<input type="checkbox"/> RECLAST® <input type="checkbox"/> BONIVA® SYRINGE <input type="checkbox"/> FORTEO®	<input type="checkbox"/> ZOMETA®	<input type="checkbox"/> OTHER: _____	Dosage and Frequency: _____	Anticipated Start Date
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INDICATION / DIAGNOSIS

<input type="checkbox"/> Prevention of Postmenopausal Osteoporosis <input type="checkbox"/> Postmenopausal Osteopenia <input type="checkbox"/> Treatment of Postmenopausal Osteoporosis <input type="checkbox"/> Osteoporosis in Men <input type="checkbox"/> Hypogonadal Osteoporosis in Men <input type="checkbox"/> Prevention of Glucocorticoid-Induced Osteoporosis <input type="checkbox"/> Glucocorticoid-Induced Osteoporosis <input type="checkbox"/> Adult Paget's Disease <input type="checkbox"/> Minimal Trauma Hip Fracture (e.g. a fall from a standing or lower height) <input type="checkbox"/> Hypercalcemia of Malignancy <input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Osteolytic lesions due to metastases	<input type="checkbox"/> Documented bone metastases from solid tumors, in conjunction with standard antineoplastic therapy <input type="checkbox"/> Documented bone metastases associated with prostate cancer, when the disease has progressed following treatment with at least one course of hormonal therapy <input type="checkbox"/> Prophylaxis of drug-induced osteopenia due to androgen deprivation therapy for prostate cancer <input type="checkbox"/> Prophylaxis of drug-induced osteopenia due to hormone therapy for breast cancer <input type="checkbox"/> Other Indication _____
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CLINICAL INFORMATION (Check ALL that apply)

<input type="checkbox"/> Yes <input type="checkbox"/> No Completed 12 month trial of Oral bisphosphonates with no improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No Unable to tolerate oral bisphosphonates? <input type="checkbox"/> Yes <input type="checkbox"/> No Moderate to high risk for bone fractures <input type="checkbox"/> Yes <input type="checkbox"/> No Completed Central DXA Bone Mineral Density T-score in hips and/or spine (list score) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient ≥18 years of age and expected to be on glucocorticoids for at least 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No Serum alkaline phosphatase elevations that are ≥ two times the upper limit of the age specific normal reference range <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient at risk for complications from the disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Will the patient be receiving the drug in the physician's office? If no, list name of servicing provider:
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PHYSICIAN SIGNATURE	DATE
_____ Prescribing Physician	_____

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. We recommend you contact BCBSLA at 800-922-8866 to verify benefits. 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.

Incomplete forms will not be processed