



ORAL BISPHOSPHONATES CERTIFICATION FAXBACK

**INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5 DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE
		ZIP

The nonpreferred oral bisphosphonates listed below require physician written certification as of October 1, 2009. Coverage for oral bisphosphonates will be limited to preferred agents alendronate, Fosamax Plus D[®], and Boniva[®], unless written certification is provided by the physician stating that the patient meets the specific criteria listed in the signature box below.

DIAGNOSIS: _____

NONPREFERRED DRUG REQUESTED:

- Actonel[®]
- Actonel[®] with Calcium

PREFERRED DRUG(S) TRIED (Check at least one box):

- Alendronate (generic or brand Fosamax[®])
- Alendronate / vitamin D3 (Fosamax Plus D[®])
- Ibandronate (Boniva[®])

Please certify the following by signing and dating below:

The **above-referenced patient has previously used alendronate, Fosamax Plus D[®], or Boniva[®]**, and such drug has been detrimental to the patient's health or has been ineffective in treating the patient's condition and, in my opinion, is likely to be detrimental to the patient's health or ineffective in treating the condition again.

Prescriber's Signature Required: _____ Date: _____

Fax completed form to 1-888-348-7332