reliance|rx℠
15 Earhart Drive, Suite 101, Amherst, NY 14221

BONIVA INJECTION AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name First Name	Today's Date Date Needed
Date of Birth: Sex: Weight:	Prescriber Specialty
Home Phone Number ( ) Work Phone Number ( )	Phone Number ( ) Fax Number ( )
Home Address City State Zip	Address City State Zip
Member's Insurance ID:	Office Phone: Office Fax Number:
Allergies:	Office Contact:

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD10 Code: _____

Date of Diagnosis: _____

Serum Calcium Level: _____ Date:_____

Serum Creatinine Level: _____ Date:_____

Prior Treatments: _____

Current Treatment: _____

Is female patient post-menopausal? ☐ Yes ☐ No

Does patient have osteoporosis (determined by bone density > 2.5 standard deviations below the mean T-score > 2.5)? ☐ Yes ☐ No

Does patient have a documented inability to swallow, or an esophageal diagnosis that prevents oral bisphosphonate administration? ☐ Yes ☐ No

*For Homebound Patients Only:

Does patient have an illness or injury that restricts his/her ability to leave his / her residence except with the aid of supportive devices, such as canes, crutches, wheelchair, walker, special assistance or the assistance of another person; or is leaving the home medically contraindicated? ☐ Yes ☐ No

DRUG NAME: BONIVA

☐ New Authorization ☐ Reauthorization*

Dose: _____

Frequency: _____

Expected Duration of Therapy: _____

***For Re-Authorization:**

Serum Calcium Level: _____ Date:_____

Serum Creatinine Level: _____ Date:_____

Has patient tolerated and responded well to therapy?

☐ Yes ☐ No