



Osteoporosis Injectable Medication Precertification Request

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: Start of treatment Continuation of therapy, date of last treatment _____ **Today's date:** _____

Ship to: Doctor's office Patient Other: _____ **Date needed:** _____
Phone: _____

Dispensing Provider: Aetna Specialty Pharmacy® or Other: _____
Phone: _____ Fax: _____ **TIN:** _____ **PIN:** _____

Precertification Requested By: _____ **Phone:** _____ **Fax:** _____

A. PATIENT INFORMATION

First Name: _____		Last Name: _____	
Address: _____		City: _____	State: _____ ZIP: _____
Home Phone: _____		Work Phone: _____	Cell Phone: _____
DOB: _____	Allergies: _____		Email: _____
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If Yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name: _____		Last Name: _____ (Circle one): M.D. D.O. N.P. P.A.	
Address: _____		City: _____	State: _____ ZIP: _____
Phone: _____	Fax: _____	St Lic #: _____	NPI #: _____ DEA #: _____ UPIN: _____
Provider Email: _____		Office Contact Name: _____ Phone: _____	

Specialty (Check one): GYN Orthopedic Primary Provider Other: _____

D. DIAGNOSIS INFORMATION

Primary ICD-9: (733.0-733.09) (Osteoporosis/Osteopenia) Other ICD-9 Code: _____

E. CLINICAL INFORMATION

Yes No Is the patient unable to remain in an upright position during post oral bisphosphonate administration?

Yes No Does the patient have documented treatment failure after an adequate trial of at least two oral bisphosphonates?
If yes, please check all that apply: Fosamax or Fosamax plus D (alendronate) Didronel (etidronate) Skelid (tiludronate)
 Actonel or Actonel with Calcium or Atelvia (risedronate) Oral Boniva (ibandronate) Other: _____

Yes No Does the patient have documented treatment failure after an adequate trial of at least one oral bisphosphonate and one SERM?
If yes, please check all that apply: Fosamax or Fosamax plus D (alendronate) Didronel (etidronate) Skelid (tiludronate)
 Actonel or Actonel with Calcium or Atelvia (risedronate) Oral Boniva (ibandronate) Other: _____
 Tamoxifen (nolvadex) Evista (raloxifene) Femara (letrozole) Fareston (toremifene)

Yes No Does the patient have a documented medical reason (intolerance, hypersensitivity, and/or contraindication) to avoid using oral bisphosphonates or SERMS?

Yes No Does the patient have Dysphagia (difficulty swallowing)?

Please check or list all indications that apply to this patient: *If any of these are checked, please refer to the product package insert for appropriate indications, warnings, and contraindications.*

Presence or history of osteoporotic vertebral compression fracture and/or hip fracture
 Currently taking calcium and Vitamin D BMD greater than -2.5 BMD -1.0 and -2.5 Other: _____

F. PRESCRIPTION – To be completed for precertification request. Prescriptions will be forwarded to Aetna Specialty Pharmacy unless otherwise noted.

MEDICATION	PRECERT	ASRx DISPENSING?	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Ibandronate Sodium (Boniva®) Injection CPB # 0727	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Calcitonin Salmon (Miacalcin®) CPB # 0803	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Zoledronic Acid (Reclast®) CPB # 0524	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Denosumab (Prolia®) CPB # 0804	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Teriparatide (Forteo®) CPB # 0666	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No				

***If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.**
***If the prescriber is providing the drug, the provider must verify benefits.**
Prescriber's Signature: _____ **Date:** ____ / ____ / ____
(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)
Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY" in this space: _____