US Family Health Plan
Prior Authorization Request Form for
Oral Bisphosphonates

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Which medication is requested?	☐ **Binosto** (alendronate 70 mg effervescent tablet) – **Proceed to question 2** ☐ **Fosamax Plus D** (alendronate 70 mg + vitamin D) – **Proceed to question 4** ☐ **All others** – **Proceed to question 5**	
2. *(Binosto request)* **Does the patient have swallowing difficulties and cannot consume 8 ounces (1 cup) of water?**	☐ Yes Proceed to question 3	☐ No Proceed to question 5
3. *(Binosto request)* **Does the patient have a sodium restriction?**	☐ Yes Proceed to question 5	☐ No Sign and date below
4. *(Fosamax Plus D request)* **Can the patient take alendronate and vitamin D as 2 separate tablets?**	☐ Yes Proceed to question 5	☐ No Sign and date below
5. Has the patient experienced significant or intolerable adverse effects from alendronate or ibandronate tablets?	☐ Yes Sign and date below	☐ No Proceed to question 6
6. Does the patient have a contraindication to alendronate or ibandronate tablets?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[09 November 2016]