

## **Binosto (alendronate effervescent) Prior Authorization Request Form Caterpillar Prescription Drug Benefit**



Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

	URGENT		
MEMBER INFORMATION			
LAST NAME:	FIRST NAME:		
PHONE NUMBER:	DATE OF BIRTH:		
STREET ADDRESS:			
CITY:	STATE: ZIP CODE:		
PATIENT INSURANCE ID NUMBER:			
MALE FEMALE HEIGHT (IN/CM): WEIGI	HT (LB/KG): ALLERGIES:		

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: https://magellanrx.com/member/external/commercial/common/doc/en-us/phi\_disclosure\_authorization.pdf

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): \_\_\_\_\_ AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: \_\_\_\_\_

PRESCRIBER INFORMATION				
LAST NAME:	FIRST NAME:			
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:			
NPI NUMBER:	DEA NUMBER:			
PHONE NUMBER:	FAX NUMBER:			
STREET ADDRESS:				
CITY:	STATE: ZIP CODE:			
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:			

MEDICATION OR MEDICAL DISPENSING INFORMATION					
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:		
NEW THERAPY	RENEWAL	IF RENEWAL: DATE THERAPY	INITIATED:		
DURATION OF THERAPY (SPECIFIC DATES):					

Continued on next page.



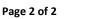






MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:				
1. HAS THE PATIENT TRIED ANY OTH	ER MEDICATIONS FOR THIS CONDITION	I? YES (if yes, complete below) NO			
MEDICATION/THERAPY (SPECIFY	<b>DURATION OF THERAPY</b> (SPECIFY	RESPONSE/REASON FOR			
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:			
2. LIST DIAGNOSES:		ICD-10:			
<b>3. REQUIRED CLINICAL INFORMATIO</b> PRIOR AUTHORIZATION.	N: PLEASE PROVIDE ALL RELEVANT CLIN	ICAL INFORMATION TO SUPPORT A			
Clinical information:					
Has the patient taken any oral capsu	les or tablets within the last 6 months?	P □ Yes □ No			
Are there any other comments, diag	noses, symptoms, medications tried or	failed, and/or any other information the			
physician feels is important to this review?					
<b>Please note:</b> Not all drugs/diagnosis a information is received.	are covered on all plans. This request ma	ay be denied unless all required			
ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that					
the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical					
information necessary to verify the a	ccuracy of the information reported on t	this form.			
Prescriber Signature or Electronic I.D	D. Verification:	Date:			
	ccompanying this transmission contain confidenti				
		bution, or action taken in reliance on the contents			
of these documents is strictly prohibited. If yo and arrange for the return or destruction of t	ou have received this information in error, please	notify the sender immediately (via return FAX)			
and analige for the return or destruction of t	nese uocuments.				

FAX THIS FORM TO: 800-424-7640 MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program Attn: CP - 4201 P.O. Box 64811 St. Paul, MN 55164-0811





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