Warning (see full prescribing information for details)
1. May cause a decrease in calcium values.
2. Must be administered intravenously. Care must be taken not to administer intra-arterially or paravenously as this could lead to tissue injury.
3. Osteonecrosis of the jaw has been reported in patients treated with bisphosphonates.
4. Atypical, low-energy or low trauma fractures of the femoral shaft have been reported in bisphosphonate-treated patients.

FDA Indications (see full prescribing information for disease specific dosage and administration)

Osteoporosis
- Increases bone mineral density in postmenopausal women with documented osteoporosis.
- Lowers the risk of vertebral fractures.

Medical Coverage Criteria
Boniva® (ibandronate IV)

Member Name: ___________________________  Prescriber Name: ___________________________
Prescriber Specialty: _______________________

Member Date of Birth: ________________  Prescriber Phone: ___________________________
Member ID #: ____________________________  Prescriber Fax: ____________________________
Member PCP Name & Address: ___________________________  Name & Location of Infusion Center: _________

Start Here

Member and Prescriber Information

Criteria
Complete patient specific and condition specific criteria.
Submit all pages of ibandronate intravenous criteria for coverage document.
Diagnosis of non-FDA approved indications require condition specific specialist referral and submission of medical record documentation outlining the treatment and follow-up plan.

Current status of patient therapy (check a box)

☐ New to ibandronate intravenous therapy
☐ Continuing ibandronate intravenous therapy (start date: ________________ )

Primary indication being treated:

Drug                          Status
-----------------------------------------------
Alendronate tablets
☐ active  ☐ discontinued  ☐ not used
Risedronate tablets
☐ active  ☐ discontinued  ☐ not used
Ibandronate tablets
☐ active  ☐ discontinued  ☐ not used
Teriparatide (Forteo)
☐ active  ☐ discontinued  ☐ not used
Zoledronic acid (Reclast)
☐ active  ☐ discontinued  ☐ not used
Denosumab (Prolia)
☐ active  ☐ discontinued  ☐ not used
Other:
☐ active  ☐ discontinued  ☐ not used

Regimen Detail

Anticipated Start Date: ________________  Stop Date: ________________  Dosing Frequency: ________________

Sign and Date

Prescriber Signature: ___________________________  Date: ________________
Prescriber NPI: ____________________________

Mail or Fax this form and clinical documentation using the number below.

Mailing Address
Physicians Plus Insurance Corporation
Attn: Pharmacy Services
P.O. Box 2078
Madison, WI  53701-2078

Physicians Plus Pharmacy Services Fax
(608) 327-0324

Prior Authorization Questions
(608) 260-7803 or (800) 545-5015
www.pplusic.com/providers
Condition Specific Criteria
(complete and submit this page, too)

- □ Post-menopausal woman
- □ Unable to swallow:
  Provide details:____________________
- □ Osteoporosis
  □ □ BMD, T-score less than -2.0
  □ □ No uncorrected hypocalcemia
- □ Failed at least three formulary agents
  (refer to page 1)
  □ □ Alendronate
  □ □ Risedronate
  □ □ Reclast
  □ □ ______________________

Describe in detail the nature of not using listed formulary therapies (supply clinic notes for off-label use)

Remember to sign and date request form before submitting