

Referral Form for IV Boniva

Today's Date _____

Patient Name _____

Phone _____ Date of Birth _____

Referring MD _____

ONLY INSURANCE APPROVED DIAGNOSIS *(Please Circle One Diagnosis)*

733.01 Postmenopausal Osteoporosis

733.09 Drug-induced Osteoporosis

INSURANCE REQUIREMENT: Patient must have one of the above diagnoses documented. Patient must have failed oral therapy and have documentation of failure. IV Boniva is not indicated for any other use.

REQUIRED: Reason for the IV therapy (versus oral therapy)

PLEASE FAX THE FOLLOWING INFORMATION WITH THIS FORM

- 1. FRONT AND BACK OF THE PATIENT'S MOST RECENT INSURANCE CARD**
 - 2. PATIENT'S DEMOGRAPHIC INFORMATION**
 - 3. RECENT CREATININE & CALCIUM LEVELS (WITHIN 6 MONTHS)**
- WE WILL PRE-CERTIFY COVERAGE OF THE THERAPY WITH YOUR PATIENT'S INSURANCE CARRIER**
- AFTER PRE-CERTIFYING WE WILL CONTACT YOUR PATIENT TO SCHEDULE TREATMENT**