34415

KANSAS MEDICAID
PRIOR AUTHORIZATION
For Non-Preferred Drugs
Bishosphonates

Request Date ___ / ___ / ____

BENEFICIARY INFORMATION

Beneficiary Medicaid ID Number

Beneficiary Date of Birth ___ / ___ / ____

Beneficiary Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City

State

Zip Code -

Prescriber Phone: - -

Prescriber Fax: - -

Prescriber Medicaid ID #

Prescriber NPI #

NDC Requested:

Strength _____ Quantity _____ Length of Therapy on Prescription _____

Indicate: Preferred Drug Tried_____ Length of trial:_____

Prescription instructions(sig):_____

Unless otherwise indicated, the chemical name includes branded products

Bisphosphonates			
Preferred Drug Covered		**Non-preferred Prior Authorization Required**	
Alendronate	Fosamax®	Risedronate	Actonel®
Alendronate/Cholecalciferol	Fosamax Plus D®	Risedronate/Calcium	Actonel® with Calcium
		Risedronate	Atelvia®
		Non-preferred	
		Ibandronate	Boniva®

Check: the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:

( ) Medical intolerance to Preferred Drug. Provide clinical symptoms:_____

( ) Inadequate response to Preferred Drug.

( ) Absence of appropriate formulation or indication of the drug. Please specify:_____

Signature of Prescriber_____ Date ___ / ___ / ____

*Prescriber signature mandatory

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FAX TO: **KANSAS Medicaid Prior Authorizations**

Fax: (866) 246-8512

PA HELPDESK: (877) 475 - 7567