

Alaska Medicaid

BISPHOSPHONATES Oral Formulation

Actonel® (all strengths), Atelvia®, Binosto® Eff, Boniva®, Fosamax + D

Criteria for Approval:

- Coverage will be given for Alendronate sodium (5mg, 10mg, 35mg, 40mg, 70mg)
- Coverage will be given to Actonel, Atelvia, ibandronate (generic Boniva), or Fosamax + D if the recipient has completed a minimum of 30 day trial or documentation of adverse reaction to alendronate
 - For Binosto, please submit additional documentation supporting use of effervescent dose form over tablet formulation
- If alendronate trial is not an option, please submit medical rationale and letter of medical necessity

Length of Authorization:

- Coverage may be approved for 1 year.

Dispensing Limit:

- The dispensing limit is a 30 day supply of medication

Reminder: You are encouraged to report negative side effects of prescription drugs to the FDA. Visit <http://www.fda.gov/Safety/MedWatch/default.htm> or call 1-800-FDA-1088