Reclast

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis or indication?

❒ Paget's disease of bone, *No further questions*
❒ Treatment or prevention of postmenopausal osteoporosis, *Continue to 2*
❒ Treatment to increase bone mass in a man with osteoporosis, *Continue to 2*
❒ Glucocorticoid-induced osteoporosis, *Continue to 2*
❒ Other, please specify. _____, *No further questions*

Send completed form to: Priority Partners Fax: 1-866-212-4756

 Reclast [zoledronic acid 5mg] SGM 2380-A – 09/2023.

2. Is the request for continuation of therapy?
❒ Yes, *Continue to 3*
❒ No, *Continue to 8*

3. Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 8*

❒ No, *Continue to 4*

❒ Unknown, *Continue to 8*

4. How long has the patient been receiving the requested drug?

❒ Less than 24 months, *Continue to 5*

❒ 24 months or more, *Continue to 6*

5. Has the patient experienced clinically significant adverse events during therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. Has the patient experienced clinical benefit to therapy (i.e., improvement or stabilization in T-score since the previous bone mass measurement)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Has the patient experienced any adverse effects?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. What is the diagnosis or indication?

❒ Treatment or prevention of postmenopausal osteoporosis, *Continue to 9*

❒ Treatment to increase bone mass in a man with osteoporosis, *Continue to 16*

❒ Glucocorticoid-induced osteoporosis, *Continue to 11*

9. Does the patient have a history of fragility fractures? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 10*

10. What is the patient's pre-treatment T-score? Please provide the patient's T-score prior to initiation of osteoporosis treatment. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record.
❒ -2.5 or below (e.g., -2.6, -2.7, -3) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *No further questions*

11. Is the patient currently receiving or will be initiating glucocorticoid therapy at an equivalent prednisone dose of greater than or equal to 2.5 mg/day for at least 3 months?

❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Does the patient have a history of a fragility fracture? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 13*

13. What is the patient's pre-treatment T-score? Please provide the patient's T-score prior to initiation of osteoporosis treatment. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record.
❒ -2.5 or below (e.g., -2.6, -2.7, -3) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 14*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 14*
❒ Unknown, *Continue to 14*

14. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for any major fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).
❒ Greater than or equal to 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Less than 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 15*
❒ Unknown, *Continue to 15*

15. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for hip fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).
❒ _____ %, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Unknown, *No further questions*

16. Does the patient have a history of an osteoporotic vertebral or hip fracture? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 17*

17. What is the patient's pre-treatment T-score? Please provide the patient's T-score prior to initiation of osteoporosis treatment. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record.
❒ -2.5 or below (e.g., -2.6, -2.7, -3) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 18*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 18*

❒ Unknown, *Continue to 18*

18. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for any major fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).
❒ Greater than or equal to 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Less than 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*

❒ Unknown, *Continue to 19*

19. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for hip fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).
❒ _____ %, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *No further questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com