JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Zometa, zoledronic acid

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 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* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

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

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

 Zometa, zoledronic acid 4mg SGM 2382-A – 04/2023.

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

Criteria Questions:

1. What is the prescribed drug?
   - ❑ Zometa
   - ❑ zoledronic acid 4mg (generic)
   - ❑ Other _____
2. What is the diagnosis?
   - ❑ Hypercalcemia of malignancy
   - ❑ Multiple myeloma
   - ❑ Bone metastases from solid tumors
   - ❑ Prostate cancer
   - ❑ Breast cancer
   - ❑ Systemic mastocytosis
   - ❑ Langerhans cell histiocytosis with bone disease
   - ❑ Other _____
3. What is the ICD-10 code? _____
4. Is the request for continuation of therapy with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section*
5. Is the patient diagnosed with hypercalcemia of malignancy? ❑ Yes ❑ No
6. Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement? ❑ Yes ❑ No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Prostate Cancer

7. Is requested medication prescribed for the treatment or prevention of osteoporosis during androgen-deprivation therapy (ADT) for a patient with a diagnosis of prostate cancer? ❑ Yes ❑ No

Section B: Breast Cancer

8. Is requested medication prescribed for a postmenopausal patient (natural or induced by ovarian suppression) who is receiving adjuvant therapy for the treatment of breast cancer? ❑ Yes ❑ No
9. Is the requested medication prescribed to maintain or improve bone mineral density and reduce the risk of fractures? *If Yes, no further questions* ❑ Yes ❑ No
10. Is the requested medication prescribed for risk reduction of distant metastasis in high-risk node negative or node positive tumors? ❑ Yes ❑ No

Section C: Systemic Mastocytosis

11. Is the requested medication prescribed for the treatment of osteopenia or osteoporosis in a patient with systemic mastocytosis? ❑ Yes ❑ No

Section D: Multiple Myeloma, Bone Metastases Requested Medication Prescribed to Maintain or Improve Bone Mineral Density and Reduce the Risk of Fractures from Solid Tumors

12. Is the requested medication being used to prevent skeletal-related events? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

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

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