



Prior Authorization Form Bisphosphonate Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Zoledronic acid (Reclast®)
 Quantity _____ Refill x _____ months
 Instructions _____
 Physician's signature _____ Provider NPI: _____ MD# _____
 Date: _____ Date medication needed _____

Patient Information

Patient's name _____
 Patient's address _____
 City, State, Zip: _____
 Patient's phone # _____
 Patient's ID#: _____ DOB _____

Prescriber Information

Prescribing physician _____
 Office address _____
 City, State, Zip: _____
 Office contact _____
 Office # _____ Fax# _____

Upon approval, delivery is available. Complete section below.

<input type="checkbox"/> No Delivery Requested	<input type="checkbox"/> Delivery Requested
<input type="checkbox"/> Physician Supply, authorization only [Flex series]	<input type="checkbox"/> Physician's office <input type="checkbox"/> Patient's home
<input type="checkbox"/> Member Pick up at pharmacy if benefit available	Preferred Vendor: _____

****A copy of the prescription must accompany the medication request****

1. DIAGNOSIS FOR DRUG REQUESTED

Paget's disease (731.0) Postmenopausal osteoporosis (733.01)
 Other (specify & include ICD-9) _____

2. PATIENT'S INFORMATION:

PAGET'S DISEASE:

A. Does the patient have any of the following conditions?

- An individual is symptomatic Yes No
- An individual is at risk for complications from the disease Yes No
- Elective surgery is planned for the pagetic site (eg. hip replacement surgery) Yes No N/A
- Serum alkaline phosphatase elevations that are two times or higher than the upper limit of the age specific normal reference range (20-130IU/L or 0.33-2.17mckat/L) Yes No

POSTMENOPAUSAL OSTEOPOROSIS:

B. Does the patient have any of the following conditions?

- Contraindication to oral bisphosphonates Yes No
- Difficulty swallowing oral medications or inability to sit upright for 30 to 60 minutes Yes No
- History of esophagitis, gastritis, gastric ulcer, esophageal stricture or esophageal motility disorder Yes No
- Failure with adequate trial of two oral bisphosphonates Yes No

3. PATIENT HISTORY

History of failed osteoporosis drug therapy:

Drug name	Dates	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (215) 761-9165 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Internal use only	Vendor _____	Billing Code _____	M / Rx
Document # _____	LOB _____	Processor Initials _____	
M F Rx coverage Y N	STANDARD - SELECT	Date _____	
Previous Auth Y N	Auth# _____	From _____ To _____	
Approved Reviewer Initials _____	Date _____	Coverage effective date / /	