AmeriHealth

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.

☐ **No Delivery Requested**	☐ **Delivery Requested**	
☐ **Physician Supply, authorization only [Flex series]**	☐ **Physician's office**	☐ **Patient's home**
☐ **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 / /

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