



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

[] Member Pick up at pharmacy if benefit available [] Physician's office [] Patient's home

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:

Table with 3 columns: Drug name, Dates, Duration

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

FAX TO (888) 671-5285 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

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