



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 (215) 761-9165 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 / /