



**Independence
Blue Cross**

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

Document # _____

M F Rx coverage Y N

Previous Auth Y N

Approved Reviewer Initials _____

Vendor _____

LOB _____

STANDARD - SELECT

Auth# _____

Date _____ Coverage effective date / /

Billing Code _____ **M / Rx**

Processor Initials _____

Date _____

From _____ To _____