Reclast

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Criteria Questions:

1. What is the diagnosis or indication?
   - ❑ Paget's disease of bone
   - ❑ Treatment or prevention of postmenopausal osteoporosis
   - ❑ Treatment to increase bone mass in a man with osteoporosis
   - ❑ Glucocorticoid-induced osteoporosis
   - ❑ Other _____
2. What is the ICD-10 code? _____
   If indication is Paget's disease of bone, no further questions.
3. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #9*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Reclast [zoledronic acid 5mg] SGM - 06/2021.

4. Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #9* ❑ Yes ❑ No ❑ Unknown

5. Has the patient experienced clinical benefit as evidenced by a bone mass measurement showing an improvement or stabilization in T-score compared with the previous bone mass measurement? ❑ Yes ❑ No *If No, skip to #7*

6. Has the patient experienced any adverse effects? ❑ Yes ❑ No *No further questions*

7. How long has the patient been receiving zoledronic acid or Reclast? _____ months

8. Has the patient experienced a clinical benefit from therapy as evidenced by no adverse events during therapy (i.e., no clinically significant adverse reaction to the requested drug, no new fracture seen on radiography)?
❑ Yes ❑ No *No further questions*

9. What is the patient's pre-treatment T-score? *Please provide the patient's T-score prior to initiation of osteoporosis treatment.* _____ ❑ Unknown
*If diagnosis is Treatment or prevention of postmenopausal osteoporosis or If T-score is less than or equal to -2.5 (*e.g., -2.6, -2.7, -3*), skip to diagnosis section*

10. What is the patient's pre-treatment FRAX score for any major fracture? (See Appendix). *Please provide the patient's FRAX score prior to initiation of osteoporosis treatment.* _____ % ❑ Unknown *If greater than or equal to 20%, skip to diagnosis section.*

11. What is the patient's pre-treatment FRAX score for hip fracture? (See Appendix). *Please provide the patient's FRAX score prior to initiation of osteoporosis treatment.* _____ % ❑ Unknown

Complete following section based on the patient's diagnosis, if applicable.

Section A: Treatment or Prevention of Postmenopausal Osteoporosis
12. Does the patient have a history of fragility fractures? ❑ Yes ❑ No

Section B: Treatment to Increase Bone Mass in a Man with Osteoporosis
13. Does the patient have a history of an osteoporotic vertebral or hip fracture? ❑ Yes ❑ No

Section C: Glucocorticoid-Induced Osteoporosis
14. Is the patient currently receiving or will be initiating glucocorticoid therapy at an equivalent prednisone dose of greater than or equal to 2.5 mg/day for at least 3 months? ❑ Yes ❑ No

15. Does the patient have a history of fragility fracture? ❑ Yes ❑ No

Appendix:
*Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp
The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg per day.

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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