

Pharmacy

PRIOR AUTHORIZATION FORM

Last Reviewed: January 2012

Last Updated: January 2012

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

 This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Reclast[®] (zoledronic acid)

 URGENT (life threatening)

 Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

 Provider Signature

 Date

PRODUCT INFORMATION

 Reclast[®] 5 mg/100 mL

Dose: _____

Start Date: _____

Note: Therapies being continued beyond 5 years of combined treatment with bisphosphonates or Prolia must submit evidence of patient's continued high risk for a future fracture.

BILLING INFORMATION

Place of administration:

- Provider's Office
 Outpatient infusion center
 Name of Center: _____
 Other: _____

Billing Options:

- Physician buy and bill (J3488)
 Preferred Specialty Vendor
 Other: _____

Request:

- New – Complete Section A
 Continuation – Complete Section B

PRIORITY HEALTH PRECERTIFICATION REQUIRMENTS

 Authorization for Reclast[®] (zoledronic acid) requires the following information to certify:

Patient must have met the following requirements:

- Diagnosis of prevention of osteoporosis in postmenopausal women, treatment of postmenopausal osteoporosis, treatment of osteoporosis in men, treatment of Paget’s disease, or treatment of glucocorticoid-induced osteoporosis.
- Documented therapeutic trial and clinical failure of (step 1) alendronate, and also with (step 2) Actonel.

For continuation, patient must have met the following requirements:

- The patient has not received more than 5 years of total treatment with a bisphosphonate or Prolia in a lifetime, unless at high risk for fracture, such as:
 - long-term corticosteroid user, using doses equal to or greater than 7.5 mg prednisone for 3 months or longer, untreated hypogonadism, either spontaneous or surgical premature menopause less than age 45, hyperparathyroidism, hyperthyroidism, chronic liver disease, patient has epilepsy and is currently taking anticonvulsant therapy, documentation of previous fragility fractures

SECTION A – NEW THERAPY
PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION IS REQUIRED FOR REIMBURSEMENT

 Authorization for Reclast[®] (zoledronic acid) requires the following information to certify:

1. What is the patient’s diagnosis?

- | | |
|--|----------------|
| <input type="checkbox"/> Treatment of postmenopausal osteoporosis | ICD code _____ |
| <input type="checkbox"/> Prevention of postmenopausal osteoporosis | ICD code _____ |
| <input type="checkbox"/> Paget’s disease | ICD code _____ |
| <input type="checkbox"/> Osteoporosis in male | ICD code _____ |
| <input type="checkbox"/> Glucocorticoid-induced osteoporosis | ICD code _____ |
| <input type="checkbox"/> Other: _____ | ICD code _____ |

Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug’s use for the identified indication.

2. Which of the following step therapy medications has the patient had a documented therapeutic trial and clinical failure with (both alendronate and Actonel required for certification)?

	Dosage	Trial Dates	Outcome
<input type="checkbox"/> alendronate	_____	_____	_____
<input type="checkbox"/> Actonel [®]	_____	_____	_____

or

- Patient has not met step therapy due to one of the following reasons:
 - Patient has Barrett’s esophagus
 - Patient has Zollinger-Ellison syndrome
 - Patient has an anatomic gastroesophageal abnormality expected to have safety risks with use of oral bisphosphonates.
Describe abnormality (e.g. gastric bypass): _____
 - Patient is unable to remain upright or standing for 30 to 60 minutes

Note: Intolerance to oral bisphosphonates due to dyspepsia/acid reflux requires a documented trial and failure with both alendronate and Actonel.

SECTION B – CONTINUATION

to be completed for patient's in which Reclast[®] (zoledronic acid) was previously authorized by Priority Health

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for continuation of Reclast[®] (zoledronic acid) requires the following information to certify:

A. What is the patient's diagnosis?

- | | |
|--|----------------|
| <input type="checkbox"/> Treatment of postmenopausal osteoporosis | ICD code _____ |
| <input type="checkbox"/> Prevention of postmenopausal osteoporosis | ICD code _____ |
| <input type="checkbox"/> Paget's disease | ICD code _____ |
| <input type="checkbox"/> Osteoporosis in male | ICD code _____ |
| <input type="checkbox"/> Glucocorticoid-induced osteoporosis | ICD code _____ |
| <input type="checkbox"/> Other: _____ | ICD code _____ |
- Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

B. How many total years of therapy has the patient received oral or intravenous bisphosphonate or Prolia therapy?

_____ years, _____ months

C. Which of the following conditions place the patient at continued high risk for a future fracture?

- long-term corticosteroid use; doses equal to or greater than 7.5 mg prednisone daily for 3 months or longer
- untreated** hypogonadism; either spontaneous or surgical premature menopause less than age 45
- hyperparathyroidism
- hyperthyroidism
- chronic liver disease
- patient has epilepsy and is currently taking anticonvulsant therapy
- documentation of previous fragility fractures

- Other risk factor: _____

PRIORITY MEDICARE PLANS

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

LCD A46096 09-27-2011

***** All fields must be complete and legible for Prior Authorization Review*****
Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX