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*

What is the ICD-10 code? _____

Clinical Criteria Questions:

1. What is the diagnosis or indication?

❒ Paget's disease of bone, *No further questions*
❒ Treatment of postmenopausal osteoporosis, *Continue to 2*
❒ Prevention of postmenopausal osteoporosis, *Continue to 2*
❒ Treatment to increase bone mass in a man with osteoporosis, *Continue to 2*
❒ Glucocorticoid-induced osteoporosis, *Continue to 2*
❒ Other, please specify. _____, *No further questions*

2. Is the request for continuation of therapy?

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

 Reclast [zoledronic acid 5mg] SGM 2380-A – 04/2024.

❒ Yes, *Continue to 3*
❒ No, *Continue to 8*

3. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 8*

❒ No, *Continue to 4*

❒ Unknown, *Continue to 8*

4. How long has the patient been receiving the requested drug?

❒ Less than 24 months, *Continue to 5*

❒ 24 months or more, *Continue to 6*

5. Has the patient experienced clinically significant adverse events during therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. Has the patient experienced clinical benefit to therapy (i.e., improvement or stabilization in T-score since the previous bone mass measurement)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Has the patient experienced any adverse effects?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. What is the diagnosis or indication?

❒ Treatment of postmenopausal osteoporosis, *Continue to 9*

❒ Prevention of postmenopausal osteoporosis, *Continue to 9*

❒ Treatment to increase bone mass in a man with osteoporosis, *Continue to 16*

❒ Glucocorticoid-induced osteoporosis, *Continue to 11*

9. Does the patient have a history of fragility fractures? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 10*

10. What is the patient's pre-treatment T-score? Please provide the patient's T-score prior to initiation of osteoporosis treatment. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record.

[PA Admin Instructions: (Please use fill-in-the blank format. Specify T-score.)]
❒ -2.5 or below (e.g., -2.6, -2.7, -3) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *No further questions*

11. 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, *Continue to 12*
❒ No, *Continue to 12*

12. Does the patient have a history of a fragility fracture? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 13*

13. What is the patient's pre-treatment T-score? Please provide the patient's T-score prior to initiation of osteoporosis treatment. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record.

[PA Admin Instructions: (Please use fill-in-the blank format. Specify T-score.)]
❒ -2.5 or below (e.g., -2.6, -2.7, -3) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 14*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 14*
❒ Unknown, *Continue to 14*

14. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for any major fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).

[PA Admin Instructions: (Please use fill-in-the blank format. Specify FRAX score percentage.)]
❒ Greater than or equal to 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Less than 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 15*
❒ Unknown, *Continue to 15*

15. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for hip fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).

[PA Admin Instructions: (Please use fill-in-the blank format. Specify FRAX score percentage.)]
❒ Greater than or equal to 3% _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Less than 3% _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Unknown, *No further questions*

16. Does the patient have a history of an osteoporotic vertebral or hip fracture? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 17*

17. What is the patient's pre-treatment T-score? Please provide the patient's T-score prior to initiation of osteoporosis treatment. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record.

[PA Admin Instructions: (Please use fill-in-the blank format. Specify T-score.)]

❒ -2.5 or below (e.g., -2.6, -2.7, -3) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 18*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 18*
❒ Unknown, *Continue to 18*

18. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for any major fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).

[PA Admin Instructions: (Please use fill-in-the blank format. Specify FRAX score percentage.)]
❒ Greater than or equal to 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Less than 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Unknown, *Continue to 19*

19. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for hip fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).

[PA Admin Instructions: (Please use fill-in-the blank format. Specify FRAX score percentage.)]
❒ Greater than or equal to 3% _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Less than 3% _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Unknown, *No further questions*

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)**

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

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
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