Zometa, zoledronic acid

CareFirst 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? _____

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

 Zometa, zolendronic acid SGM 2382-A – 06/2025.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. What is the diagnosis?

❒ Hypercalcemia of malignancy, *Continue to 2*

❒ Treatment of skeletal-related events due to multiple myeloma, *Continue to 2*

❒ Prevention of skeletal-related events due to multiple myeloma, *Continue to 2*

❒ Treatment of skeletal-related events due to bone metastases from a solid tumor (e.g., breast cancer, non-small cell lung cancer, thyroid carcinoma, kidney cancer, prostate cancer), *Continue to 2*

❒ Prevention of skeletal-related events due to bone metastases from a solid tumor (e.g., breast cancer, non-small cell lung cancer, thyroid carcinoma, kidney cancer, prostate cancer), *Continue to 2*

❒ Breast cancer, *Continue to 2*

❒ Treatment of osteopenia or osteoporosis due to systemic mastocytosis, *Continue to 2*

❒ Langerhans cell histiocytosis with bone disease, *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is the request for continuation of therapy with the requested drug?

❒ Yes, *Continue to 3*

❒ No, *Continue to 6*

3. Is the patient diagnosed with hypercalcemia of malignancy?

❒ Yes, *Continue to 4*

❒ No, *Continue to 5*

4. Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

5. Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

6. What is the diagnosis?

❒ Hypercalcemia of malignancy, *No further questions*

❒ Multiple myeloma, *Continue to 13*

❒ Bone metastases from a solid tumor (e.g., breast cancer, non-small cell lung cancer, thyroid carcinoma, kidney cancer, prostate cancer), *Continue to 13*

❒ Breast cancer, *Continue to 7*

❒ Systemic mastocytosis, *Continue to 12*

❒ Langerhans cell histiocytosis with bone disease, *No further questions*

7. Will the requested drug be used for treatment or prevention of skeletal-related events from bone metastases?

❒ Yes, *No Further Questions*

❒ No, *Continue to 8*

8. Is the requested drug being prescribed for a postmenopausal (natural or induced by ovarian suppression) patient who is receiving adjuvant aromatase inhibition therapy for treatment of breast cancer? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting use of aromatase inhibition therapy.
❒ Yes, *Continue to 9*
❒ No, *Continue to 10*

9. Will the requested drug be used to maintain or improve bone mineral density and reduce the risk of fractures?
❒ Yes, *No Further Questions*
❒ No, *Continue to 11*

10. Is the requested drug being prescribed for a postmenopausal (natural or induced by ovarian suppression) patient who is receiving adjuvant therapy for treatment of breast cancer?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Will the requested drug be used for risk reduction of distant metastasis in high-risk node negative or node positive tumors?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. Is the requested drug being prescribed for treatment of osteopenia or osteoporosis in a patient with systemic mastocytosis?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

13. Will the requested drug be used for treatment or prevention of skeletal-related events?
❒ Yes, *No Further Questions*
❒ No, *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
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com