

Health Plan Select

Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (706) 549-8004

Reclast® (zoledronic acid) injection

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Reclast injection 5 mg/100 ml

Dose: _____ Start date: _____

Place of Administration:

- Self-administered
 Provider's Office
 Athens Regional Ambulatory Treatment Center
 Home Infusion Name of agency: _____

Health Plan Select Precertification Requirements: Authorization of Reclast requires:

- Diagnosis of postmenopausal osteoporosis or Paget's disease
- Documented therapeutic trial of Fosamax and Actonel

Please Complete the Following Information: Diagnosis:

- Postmenopausal osteoporosis– ICD code: _____
 Paget's Disease– ICD code: _____
 Other: _____ – ICD code: _____ Please provide rationale for use:

_____ Patient's T-score is -2.5 or less?
T-score: _____ Yes No – Rationale for use:

Patient has had a documented therapeutic trial of all of the following:

- | <input type="checkbox"/> Yes | Dose | Dates | Outcome |
|--|-------|-------|---------|
| <input type="checkbox"/> Fosamax | _____ | _____ | _____ |
| <input type="checkbox"/> Actonel | _____ | _____ | _____ |
| <input type="checkbox"/> No - Rationale for use: _____ | | | |

*** All fields must be complete and legible for Prior Authorization Review***

Please fax this request to: (706) 549-8004.

YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX