Capital BLUE

ZOLEDRONIC ACID (RECLAST® AND ZOMETA ®) (MP- 2.143)

Preauthorization Request

(Preauthorization is not a guarantee of payment)

SECTION I – General Information	
Anticipated date of next infusion: / / Initial start date of therapy / /	Fax completed form to: **1-866-805-4150 toll free**

SECTION II – Member Information		
Member Name:	Member ID:	Member DOB:
Plan Type: ☐ Traditional ☐ Comprehensive ☐ PPO ☐ POS ☐ KHPC ☐ Special Care ☐ Sr. Blue HMO ☐ Sr. Blue PPO		

SECTION III – Provider Information	
Requesting Provider Name: Address:	Requesting Provider CBC # _____ NPI # _____
Telephone #:	Fax #:
Office Contact Name:	Office Contact Telephone #:
Place of Service: ☐ MD Office ☐ Name/Address of Hospital/Clinic/Home Health	

SECTION IV – Preauthorization Requirements and Clinical Criteria

Reclast®:

Diagnosis: ☐ Osteoporosis ☐ Osteopenia ☐ Paget's disease ☐ Other (specify):
ICD Code(s): **HCPC - J3489**

☐ **Initial Authorization Request**

Osteoporosis or osteopenia Indications (Maximum one year) To be completed for initial authorization

☐ Prevention of osteoporosis in postmenopausal women with osteopenia*
☐ Treatment of osteoporosis** in postmenopausal women.
☐ Prevention of new clinical fractures for patients with a recent low-trauma hip fracture
☐ Treatment to increase bone mass in men with osteoporosis**

The patient cannot tolerate or is unresponsive to oral agents? ☐ Yes ☐ No (If yes complete section IV A below.)
Patient is receiving supplemental Calcium and Vitamin D? ☐ Yes ☐ No
Secondary causes of osteoporosis excluded? ☐ Yes ☐ No
T Score at femoral neck or spine_____

Glucocorticoid Induced Osteoporosis:
Name of glucocorticoid _____Dose_____
Reason for administration of Reclast -- ☐ Prevention of osteoporosis ☐ Treatment of osteoporosis.
Patient has been or is expected to be on glucocorticoids for at least 12 months? ☐ Yes ☐ No

Paget's Disease:
☐ The patient has elevations of serum alkaline phosphatase two times or higher than the upper limit of the age-specific normal reference range.
☐ The patient is symptomatic from active bone lesions.
☐ The patient is at risk for complications from their disease

The patient cannot tolerate or is unresponsive to oral agents? ☐ Yes ☐ No (If yes complete section IV A below.)

Section IV A **Documentation of therapeutic trial and clinical failure of oral drug therapy**

Please list any previous therapies (including name of medication) that were tried and failed. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response etc.). Please attach clinic notes.

1. Name of drug(s) Trial dates / / through / /
   Reason for discontinuation

2. Name of drug(s) Trial dates / / through / /
   Reason for discontinuation

☐ **Reauthorization Request for maintenance therapy for osteoporosis or osteopenia.** Maximum one year. To be completed for continuation of therapy.

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Patient is receiving supplemental Calcium and Vitamin D? Yes ☐ No ☐

The safety and effectiveness of Reclast for the treatment of osteoporosis is based on clinical data of three years duration. The optimal duration of use has not been determined. Patients should have the need for continued therapy re-evaluated on a periodic basis.

☐ **Request for second course of treatment with Reclast for Paget's Disease of the bone.**

Patients has relapsed based on increased serum alkaline phosphatase? ☐ Yes ☐ No If yes list value_____

Patient has failed to achieve normalization of serum alkaline phosphatase? ☐ Yes ☐ No If yes list value _____

Patient is symptomatic for Paget's disease of the bone? ☐ Yes ☐ No

Zometa ®

Diagnosis:

ICD Code(s): **HCPC - J3489**

Indication

☐ Hypercalcemia of Malignancy

Please indicate cCa value _____

Note: (FDA defines hypercalcemia as an albumin-corrected calcium (cCa) of >12mg/dL [3.0mmol/L] using the formula: cCa in mg/dL + 0.8 (mid-range of measured albumin in mg/dL)

☐ Multiple Myeloma

- Is treatment with Zometa in conjunction with standard antineoplastic therapy? ☐ Yes ☐ No

Bone metastases from solid tumor

☐ Prostate Cancer

Has the cancer progressed after treatment with at least one hormonal therapy? ☐ Yes ☐ No

Is treatment with Zometa in conjunction with standard antineoplastic therapy? ☐ Yes ☐ No

☐ Other solid tumor type

Is treatment with Zometa in conjunction with standard antineoplastic therapy? ☐ Yes ☐ No

Dosing information

Frequency: Dose

SECTION VI– Required Physician Signature

Please sign:	Date: / /

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies