

## PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## Zometa (zoledronic acid)

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business:  □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

**<u>REQUEST FOR EXPEDITED REVIEW</u>**: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.		
Q1. Is this an initial request for the dr	ıg?	
□ Yes	□ No	
Q2. Is the requested drug being used to treat hypercalcemia of malignancy?		
□ Yes	□ No	
Q3. Is the requested drug being used for prevention of skeletal-related events in patients with multiple myeloma?		
□ Yes	□ No	
Q4. Is the requested drug being used for prevention of skeletal-related events in patients with bone metastases from a solid tumor?		
□ Yes	□ No	
Q5. Is the requested drug being used for patients with prostate cancer for treatment or prevention of osteoporosis during androgen deprivation therapy (ADT)?		

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 Improvement?

 Yes

 Q11. Additional Information:

Prescriber Signature

Date

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Patient	Name:
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Prescriber Name:

v2025

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