Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Zoledronic acid (Reclast)

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):**

☐ REQUEST FOR EXPEDITED REVIEW: 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 drug?

☐ Yes ☐ No

Q2. Does the patient have one the following diagnoses?

☐ Postmenopausal osteoporosis, treatment or prevention - Go to 3
☐ Osteoporosis in men - Go to 4
☐ Glucocorticoid-induced osteoporosis - Go to 5
☐ Paget's disease of bone - Go to 9

Q3. Does the patient have ANY of the following (supporting chart notes or medical records attached): A) A history of fragility fractures; B) Pre-treatment T-score less than or equal to -2.5; C) Osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1)?

☐ Yes ☐ No

Q4. 4) Does the patient have ANY of the following (supporting chart notes or medical records attached): A) A history of an osteoporotic vertebral or hip fracture; B) Pre-treatment T-score less

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than or equal to -2.5; C) Osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1) with a high pre-treatment FRAX fracture probability?

☐ Yes ☐ No

Q5. 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 ☐ No

Q6. Does the patient have ANY of the following (supporting chart notes or medical records attached): A) A history of fragility fractures; B) Pre-treatment T-score less than or equal to -2.5; C) Osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1) with a high pre-treatment FRAX fracture probability?

☐ Yes ☐ No

Q7. Does the patient have Paget's disease of bone?

☐ Yes ☐ No

Q8. For all other indications, does the patient meet ONE of the following: A) Patient has experienced clinical benefit as evidenced by a bone mass measurement showing an improvement or stabilization in T-score compared with the previous bone mass measurement and member has not experienced any adverse effects. B) Patient has received less than 24 months of therapy and has experienced clinical benefit (e.g. no new fracture seen on radiography) and has not experienced clinically significant adverse events during therapy?

☐ Yes ☐ No

Q9. Additional Information:

_____ _____

Prescriber Signature Date