Jefferson Health Plans

2024 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):**

☐ 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. 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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☐ Yes ☐ No

Q6. Is the requested drug being used for postmenopausal (natural or induced by ovarian suppression) patients receiving adjuvant therapy for treatment of breast cancer when one of the following is met: A) The requested medication will be used to maintain or improve bone mineral density and reduce the risk of fractures. B) The requested medication will be used for risk reduction of distant metastasis in high-risk node negative or node positive tumors?

☐ Yes ☐ No

Q7. Is the requested drug being used for treatment of osteopenia or osteoporosis in patients with systemic mastocytosis?

☐ Yes ☐ No

Q8. Is the requested drug being used for treatment of Langerhans Cell Histiocytosis with bone disease?

☐ Yes ☐ No

Q9. For continuation of drug for the treatment of hypercalcemia of malignancy, is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?

☐ Yes ☐ No

Q10. For continuation of drug for all other FDA-approved diagnoses and compendial uses, is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?

☐ Yes ☐ No

Q11. Additional Information:

_____ _____

Prescriber Signature Date

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