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Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Reclast® (zoledronic acid) Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Glucocorticoid-induced osteoporosis					
<input type="checkbox"/> Paget's disease					
<input type="checkbox"/> Prevention of postmenopausal osteoporosis					
<input type="checkbox"/> Treatment of osteoporosis in postmenopausal women					
<input type="checkbox"/> Treatment of osteoporosis in men					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
For glucocorticoid-induced osteoporosis, answer the following:					
Is the patient initiating or continuing on greater than or equal to 7.5 mg/day of oral prednisone (or equivalent) for at least 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have history of failure, contraindication, or intolerance to one oral bisphosphonate [e.g., Fosamax (alendronate)]? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient able to tolerate oral medications? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For Paget's disease, answer the following:					
Select if following applies to the patient to confirm a diagnosis of Paget's disease:					
<input type="checkbox"/> Elevations in serum alkaline phosphatase of greater than or equal to 2 times the upper limit of the age-specific normal reference range provided by the physician's laboratory					
<input type="checkbox"/> Patient is experiencing symptoms associated with Paget's disease (e.g., bone pain at pagetic site, radicular or arthritic pain caused by bone involvement that affects nerve roots or joints, neurological symptoms arising in the setting of active pagetic bone impacting on neural tissues)					
<input type="checkbox"/> Patient is at risk for complications (e.g., patients with active Paget's disease at skeletal sites such as the skull, spine, weight-bearing long bones, and bones adjacent to major joints such as hip or knee)					
Reauthorization:					
Has the patient's serum alkaline phosphatase failed to normalize after the previous therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient experiencing symptoms associated with Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For prevention of postmenopausal osteoporosis, answer the following:					
Does the patient have a bone mineral density (BMD) scan indicative of osteopenia defined as a t-score between negative 1.0 to negative 2.5? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have history of failure, contraindication, or intolerance to one oral bisphosphonate [e.g., Fosamax (alendronate)]? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient able to tolerate oral medications? <input type="checkbox"/> Yes <input type="checkbox"/> No					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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Reclast[®] (zoledronic acid) Prior Authorization Request Form (Page 2 of 2)

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For treatment osteoporosis in men and postmenopausal women, answer the following:

Does the patient have history of vertebral compression fractures, or fractures of the hip or distal radius from minimal trauma? Yes No

Does the patient have a bone mineral density (BMD) scan indicative of osteoporosis defined as a t-score less than or equal to negative 2.5 (2.5 standard deviations or greater below the mean for young adults)? Yes No

Does the patient have history of failure, contraindication, or intolerance to one oral bisphosphonate [e.g., Fosamax (alendronate)]? Yes No

Is the patient able to tolerate oral medications? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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