



15 Earhart Drive, Suite 101, Amherst, NY 14221

RECLAST (MALE) AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name: Today's Date: Date Needed:
Date of birth: Sex: Weight: Prescriber: Specialty:
Home Phone Number: Phone Number: Fax Number:
Home Address: City: State: Zip: Address: City: State: Zip:
Payor: Allergies: Medication ships to patient home
Insurance ID: Group Number: Medication ships to provider office

STATEMENT OF MEDICAL NECESSITY

New Authorization Re-Authorization*

DRUG SELECTION: RECLAST

Dose: Frequency:
Primary Diagnosis:
ICD10 Code:
Prior Treatments:

Is the patient male? Yes No

(If NO, please use alternate form)

-For male patients, check all that apply:

- Patient is diagnosed with osteoporosis or significant osteoporosis secondary to hypogonadism as evidenced by:
Patient has a femoral neck or lumbar spine BMD-T score less than or equal to -2.5

OR

- Patient has a femoral neck or lumbar spine BMD-T score of -2.0 to -2.4 AND the presence of at least one of the following major risk of fracture:
Age over 70 years
Existing low-trauma fracture or prevalent vertebral deformity
Radiographic evidence of osteopenia
Presence of medical conditions (hypogonadism, rheumatoid arthritis)
OR concurrent use of medications known to increase the risk for bone loss.

Please list:

OR

- Patient is diagnosed with moderate to severe Paget's disease of bone defined as serum alkaline phosphatase level at least twice the upper limit of the age-specific normal reference range.

OR

- Reclast is being administered for the prevention or treatment of glucocorticoid-induced osteoporosis in patients expected to be on glucocorticoids for at least 12 months

AND

Patient's current serum calcium levels submitted. Yes No (attached to request)

AND

Is the patient's current serum creatinine level and weight submitted for purposes of calculating creatinine clearance? Yes No (attached to request)

AND

Documentation showing that patient has been instructed about the symptoms of hypocalcemia and the importance of adequate calcium and vitamin D supplementation while on this therapy is submitted. Yes No

AND

Patient has demonstrated one of the following:

- Tried and failed to respond to oral Alendronate therapy

OR

- Has an established esophageal diagnosis or inability to swallow Alendronate

For Re-Authorization:

BMD-T Score: Date:

Serum Ca+ level: Date:

Serum creatinine level: Date:

Weight: Date: