



15 Earhart Drive, Suite 101, Amherst, NY 14221

RECLAST (FEMALE) AUTHORIZATION AND RE-AUTHORIZATION REQUEST

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

Member Name: Today's Date: Date of birth: Sex: Weight: Prescriber: Specialty: Home Phone Number: Phone Number: Fax Number: Home Address: City: State: Zip: Address: City: State: Zip: Member's Insurance ID: Allergies:

STATEMENT OF MEDICAL NECESSITY

New Authorization Re-Authorization\*

DRUG SELECTION: RECLAST

Dose: Frequency:

Primary Diagnosis:

ICD10 Code:

Prior Treatments:

Is the patient female? Yes No

(If NO, please use alternate form)

-For female patients, check all that apply:

Patient is postmenopausal with confirmed diagnosis of osteoporosis evidenced by:

Femoral neck BMD T-score less than or equal to -1.5 and at least two mild or one moderate existing vertebral fractures(s)

OR

Femoral neck BMD-T score of less than or equal to -2.5

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

OR

Reclast is being administered for the prevention of osteoporosis in a postmenopausal female patient

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

Yes No

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.

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: