reliance|rx℠
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 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 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. (attached to request) ☐ Yes ☐ No

AND

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

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: _____