Reclast (for Maryland only)
Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

1. Is Reclast prescribed for any of the following indications?
   - ❑ Paget's disease of bone, *no further questions*
   - ❑ Treatment or prevention of postmenopausal osteoporosis
   - ❑ Treatment to increase bone mass in a man with osteoporosis
   - ❑ Glucocorticoid-induced osteoporosis
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ❑ Yes ❑ No ACTION REQUIRED: ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*
6. Has the patient had at least a 1-year trial of an oral bisphosphonate? ❑ Yes ❑ No

7. *If patient has not had a trial of an oral bisphosphonate,* is there a clinical reason to avoid treatment with an oral bisphosphonate? ***Indicate below or mark "None of the above"***
   - ❑ Esophageal abnormality that delays emptying such as stricture or achalasia
   - ❑ Active upper gastrointestinal problem (eg, dysphagia, erosive esophagitis)
   - ❑ Inability to stand or sit upright for 30 to 60 minutes
   - ❑ Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink or medication of the day
   - ❑ Renal insufficiency (creatinine clearance less than 30 ml/min)
   - ❑ History of intolerance to an oral bisphosphonate
   - ❑ Other _____
   - ❑ None of the above
   - ❑ Not applicable

Complete following section based on the patient's diagnosis.

Section A: Treatment to Increase Bone Mass in a Man with Osteoporosis or Treatment or Prevention of Postmenopausal Osteoporosis

8. *If diagnosis is treatment to increase bone mass in a man with osteoporosis,* does the patient have a history of an osteoporotic vertebral or hip fracture? *If Yes, no further questions* ❑ Yes ❑ No, *skip to #12*

9. Does the patient have a history of fragility fracture? *If Yes, no further questions* ❑ Yes ❑ No

10. Does the patient have any indicators of higher fracture risk? ❑ Yes ❑ No
    If Yes, please indicate higher fracture risk indicator: _____

11. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (i.e., zoledronic acid [Reclast], teriparatide [Forteo])? ❑ Yes ❑ No

12. What is the patient's pre-treatment T-score? _____ ❑ Unknown
    If less than or equal to -2.5 (ex. -3, -4), no further questions.

13. What is the patient's pre-treatment FRAX score for any major fracture*? _____ % ❑ Unknown
    **Calculator available at http://www.shef.ac.uk/FRAX/*

14. What is the patient's pre-treatment FRAX score for hip fracture*? _____ % ❑ Unknown
    **Calculator available at http://www.shef.ac.uk/FRAX/*

Section B: Glucocorticoid-Induced Osteoporosis

15. Is the patient currently receiving or will be initiating glucocorticoid therapy? ❑ Yes ❑ No

16. Does the patient have a history of fragility fracture? *If Yes, no further questions* ❑ Yes ❑ No

17. What is the patient's pre-treatment T-score? _____ ❑ Unknown
    If less than or equal to -2.5 (ex. -3, -4), no further questions.

18. What is the patient's pre-treatment FRAX score for any major fracture*? _____ % ❑ Unknown
    **Calculator available at http://www.shef.ac.uk/FRAX/*

19. *If patient's pre-treatment FRAX score for any major fracture is less than 20%,* what is the patient's pre-treatment FRAX score for hip fracture*? _____ % ❑ Unknown
    **Calculator available at http://www.shef.ac.uk/FRAX/*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**