

Zometa, zoledronic acid
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. What is the prescribed drug? Zometa zoledronic acid (generic) Other _____
2. What is the diagnosis?
 Prostate cancer
 Bone metastases from solid tumors (other than prostate cancer)
 Multiple myeloma
 Hypercalcemia of malignancy
 Other _____
3. What is the ICD-10 code? _____

Complete the following questions if patient's diagnosis is prostate cancer.

4. Does the patient have castration-recurrent prostate cancer? Yes No *If No, skip to #6*
5. Does the patient have bone metastases? Yes No *No further questions*
6. Is zoledronic acid or Zometa requested for the treatment or prevention of osteoporosis secondary to androgen-deprivation therapy (ADT)? Yes No

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)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message Zometa, Zoledronic acid SGM – 5/2017.

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