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 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: ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self-funded Insurance ID: Group Number:	Allergies:	Medication ships to patient home 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 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. (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 ☐ 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: ________________

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