Reclast

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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

Rendering Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **HPHC Provider ID:** _____

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

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

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. Has the patient had at least a 1-year trial of an oral bisphosphonate? ❑ Yes ❑ No

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-844-851-0882

CVS Caremark Prior Authorization ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-844-387-1435 ● Fax: 1-844-851-0882 ● www.caremark.com

4. *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

5. *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 #9*

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

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

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

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

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

11. 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

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

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

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

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

16. *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)**

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