



**Reclast
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.

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: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

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

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. Reclast SGM – 10/2018.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062
Phone: 1-866-814-5506 • Fax: 1-855-330-1720 • www.caremark.com**

Criteria Questions:

1. Is Reclast prescribed for any of the following indications?
 - Paget's disease of bone
 - 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? _____
If indication is Paget's disease of bone, no further questions.
3. Has the patient had at least a 1-year trial of an oral bisphosphonate? Yes No
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, if applicable.

Section A: Treatment to Increase Bone Mass in a Man with Osteoporosis, 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 *If 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., denosumab [Prolia], teriparatide [Forteo])? Yes No
9. What is the patient's pre-treatment T-score? _____ Unknown
If diagnosis is treatment to increase bone mass in a man with osteoporosis and 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.

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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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