

Health New England
Medication Request Form (MRF) /Prescription Request

Reclast® (zolendronic acid)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

- Prior Authorization Only**
- Prior Authorization and Drug Delivery Request**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Reclast®. Please complete this form and fax to ICORE Healthcare at (866)-364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

Medication Request Information (please complete each section of this form prior to transmittal):

J-Code = J3488; (medication packaged in)

Patient Information (all required)		Physician Information (all required)	
Patient Name:		Physician Name:	
		Specialty:	
Patient Cell Phone #: () -		NPI#:	
Patient HNE ID#:		HNE Provider #:	
Patient Date of Birth:		DEA #:	
Allergies:		Telephone #: () -	
		Fax #: () -	

Drug Information

Requested Drug/Strength/Form: Reclast®			
Dose, Directions, and length of treatment (please be specific):	Quantity (per month):	Refills:	
<input type="checkbox"/> Initial Treatment <input type="checkbox"/> Retreatment 5 mg IV	1 dose annually		
Physician Signature:	Date:		

Indication:

Paget's disease of the bone

osteoporosis in postmenopausal women

osteoporosis in men

treatment and prevention of glucocorticoid-induced osteoporosis

Documentation of Medical Criteria:

elevations in serum alkaline phosphatase two times or higher the normal limit..

Relapsed based on increases in serum alk phos, failure to achieve normal alk phos or appearance of symptoms

Bone mass density (T-score) of -2.5 or lower

Intolerance to oral bisphosphonates or failure to achieve adequate response to a 12 month trial

Recent pathologic fracture or documented severe osteoporosis (T-socre worse than -3.0)

Diagnosis or chronic medical condition requiring ≥7.5mg oral corticosteroid therapy for 12 months or longer.

Other Pertinent History (relative or pertaining to this request):