Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Reclast

Prior Authorization Request

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 toll-free to Peach State Health Plan at 1-866-374-1579**. If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: ______________________ **Date**: ______________________
Patient's ID: ______________________ **Patient's Date of Birth:** ______________________
Physician's Name: ______________________
Specialty: ______________________ **NPI#:** ______________________
Physician Office Telephone: ______________________ **Physician Office Fax:** ______________________
Physician Office Address: ______________________

1. Which drug is being prescribed?
❑ Reclast, Dose: _________________ Frequency: _________________ ❑ Other ________________

2. What is the diagnosis?
❑ Glucocorticoid-induced osteoporosis ❑ Osteoporosis
❑ Paget's disease ❑ Other____________________

3. Does the patient have creatinine clearance (CrCl) greater than or equal to 35 mL/min and normal serum calcium level? ❑ Yes ❑ No

4. Is the patient currently on or will be receiving supplemental calcium plus vitamin D? ❑ Yes ❑ No

5. Has the patient had a trial of oral bisphosphate therapy (e.g., Actonel, Boniva Tablets, Didronel Tablets, Fosamax, Skelid)? ❑ Yes ❑ No **If no, skip to # 7*

6. Was the patient adherent to prescribed therapy? ❑ Yes ❑ No

7. Does the patient have any of the following contraindications or intolerance to oral bisphosphonate therapy? ❑ Yes ❑ No
❑ Renal function impairment
❑ Esophageal abnormality that delays emptying such as stricture or achalasia
❑ Active upper gastrointestinal problem (eg, dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers)
❑ Inability to stand or sit upright for at least 30 to 60 minutes
❑ Inability to take at least 30 to 60 minutes before first food, drink, or medication of the day

Complete the Section below designated for the patient's diagnosis
SECTION A: Diagnosis Glucocorticoid-induced osteoporosis

8. Is the patient either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone? ❑ Yes ❑ No

9. Is the patient expected to remain on glucocorticoids for at least 12 months? ❑ Yes ❑ No

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Patient Name: ______________________ **Patients Date of Birth:** ______________________
Patients ID : ______________________

SECTION B: Diagnosis Osteoporosis

10. What is the T-score? _______________ (**Fax copy of results**)
11. Is the patient at least 50 years of age with a fragility fracture? ❑ Yes ❑ No
12. Reclast is prescribed for: ❑ Treatment and prevention of postmenopausal osteoporosis
    ❑ To increase bone mass in a man with osteoporosis
13. Has the patient failed a trial of one year of testosterone therapy? ❑ Yes ❑ No
14. Is the patient contraindicated or intolerant to testosterone therapy? ❑ Yes ❑ No

****NOTE: We can NOT make a decision without a copy of the documentation - Thank You****

Information given on this form is accurate as of this date:

X____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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