Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Zoledronic Acid (Reclast)

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this an initial request for the drug?If YES, go to 2. If NO, go to 7.

☐ Yes ☐ No

Q2. Does the patient have one the following diagnoses?

☐ Postmenopausal osteoporosis, treatment or prevention - Go to 3
☐ Osteoporosis in men - Go to 4
☐ Glucocorticoid-induced osteoporosis - Go to 5
☐ Paget's disease of bone - Go to 9

Q3. Does the patient have ANY of the following (supporting chart notes or medical records attached):

• A history of fragility fractures;
• Pre-treatment T-score less than or equal to -2.5;
• Osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1)?

☐ Yes ☐ No

Q4. Does the patient have ANY of the following (supporting chart notes or medical records attached):

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Member Name:	**Prescriber Name:**

• A history of an osteoporotic vertebral or hip fracture;
• Pre-treatment T-score less than or equal to -2.5;
• Osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1) with a high pre-treatment FRAX fracture probability?

☐ Yes ☐ No

Q5. Is the patient currently receiving or will be initiating glucocorticoid therapy at an equivalent prednisone dose of greater than or equal to 2.5 mg/day for at least 3 months?

☐ Yes ☐ No

Q6. Does the patient have ANY of the following (supporting chart notes or medical records attached):

• A history of fragility fractures;
• Pre-treatment T-score less than or equal to -2.5;
• Osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1) with a high pre-treatment FRAX fracture probability?

☐ Yes ☐ No

Q7. Does the patient have Paget's disease of bone?

☐ Yes ☐ No

Q8. For all other indications, has the patient received less than 24 months of therapy and has not experienced clinically significant adverse events during therapy?

☐ Yes ☐ No

Q9. Has the patient received 24 months of therapy or more and meets both of the following:

• Patient has experienced clinical benefit (i.e., improvement or stabilization in T-score since the previous bone mass measurement
• Member has not experienced any adverse effects

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q10. Additional Information:

_____ _____

Prescriber Signature Date

v2025