



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Zoledronic Acid (Reclast)

Fax back to: (833) 605-4407

Phone: (215) 991-4300

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.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Exchange - PA	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 the 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 8

Yes

No

Q2. Does the patient have one the following diagnoses?

Postmenopausal osteoporosis, treatment or prevention - If YES, go to 3.

Osteoporosis in men - If YES, go to 4.

Glucocorticoid-induced osteoporosis - If YES go to 5.

Paget's disease of bone

Prostate cancer - If YES, go to 7.

Other medically accepted indication - If YES, go to 8.

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

A history of fragility fractures (e.g., low trauma fracture from force similar to a fall from standing position)

Pre-treatment T-score less than or equal to -2.5



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Osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1)

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

- 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.

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 (e.g., low trauma fracture from force similar to a fall from standing position)
- 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

Q7. Is the drug being used for treatment-related bone loss when receiving androgen deprivation therapy (ADT) (e.g., gosarelin, leuprolide, triptorelin)? Please provide chart notes, medical record documentation, or claims history supporting use of androgen deprivation therapy.

- 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:



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Patient has experienced clinical benefit (i.e., improvement or stabilization in T-score since the previous bone mass measurement)	<input type="checkbox"/> Member has not experienced any adverse effects
Q10. Additional Information:	

Prescriber Signature

Date

v2026