CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Reclast® (zoledronic acid)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ 733.0 Osteoporosis ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas that are not filled out will be considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient does not have uncorrected pre-existing hypocalcemia and disturbances of mineral metabolism ☐ Yes ☐ No
- Patient's vitamin D status has been evaluated and corrected prior to initiation of Reclast therapy AND the patient will be receiving adequate intake of supplemental calcium and vitamin D ☐ Yes ☐ No **AND**
- Patient does not have severe renal impairment (CrCl < 35 mL/min **AND** ☐ Yes ☐ No
- Patient's serum creatinine will be measure prior to each dosage administration of Reclast ☐ Yes ☐ No
- Patient has a diagnosis of Paget's disease of bone ☐ Yes ☐ No
- Patient has post menopausal osteoporosis ☐ Yes ☐ No
- Patient has a diagnosis of one of the following AND ☐ Yes ☐ No
- Prevention of new clinical fractures in patients who are at high risk of fracture (i.e., patients with a recent low-trauma hip fracture) **OR** ☐ Yes ☐ No
- Treatment or prevention of glucocorticoid-induced osteoporosis in patient who are expected to remain on glucocorticoids for at least 12 months **OR** ☐ Yes ☐ No
- Treatment of osteoporosis ☐ Yes ☐ No
- Prevention of osteoporosis in a postmenopausal woman ☐ Yes ☐ No
- Patient has a diagnosis of esophageal stricture, achalasia, or other severe esophageal dysmotility disorder ☐ Yes ☐ No
- Patient has a history of severe malabsorption making use of oral bisphosphonates ineffective ☐ Yes ☐ No
- Patient has an inability to stand or sit upright for 60 minutes ☐ Yes ☐ No
- Patient has tried and is intolerant to 2 or more oral bisphosphonates ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Reclast® (zoledronic acid)	5mg/100ml			

PRODUCT SUBSTITUTION PERMITTED (Date)

DISPENSE AS WRITTEN (Date)