09/25/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)
Reclast (IL88)
This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-844-242-0908**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Reclast (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Reclast (zoledronic acid)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Is the patient greater than 18 years of age? Y N

   [If no, no further questions.]

2. Does the patient have a diagnosis of Paget's disease of bone? Y N

   [If no, skip to question 4.]

3. Does the patient meet one of the following? Please list the medication tried and document intolerance, contraindication, or failure here: Y N

   Failure of a consecutive 6 month regimen of at least one formulary bisphosphonate (e.g., alendronate) OR \ intolerance or contraindication to at least one formulary bisphosphonate per medical records (for any length of time)

   [No further questions]

4. Does the patient have a diagnosis of corticosteroid-induced osteoporosis? Y N

   [If no, skip to question 8.]

5. Is the patient receiving treatment with 7.5mg/day oral prednisone (or equivalent) for a planned duration of at least 3 months? Y N

   [If no, no further questions.]

6. Did/does the patient have baseline T-score of less than -1.0 with DEXA scan? Please document T-Score and date here: Y N

   [If no, no further questions.]

7. Does the patient meet one of the following? Please list the medication tried and document intolerance, contraindication, or failure here: Y N

   Failure of a consecutive 6 month regimen of at least one formulary bisphosphonate (e.g., alendronate) OR \ Intolerance or contraindication to at least one formulary bisphosphonate per medical records (for any length of time)

   [No further questions.]

8. Does the patient have a diagnosis of osteoporosis? Y N

   [If no, no further questions.]

9. Has the patient had a trial and failure of a consecutive 6-month regimen of a formulary oral bisphosphonate (e.g., alendronate) as indicated by one of the following? Please list the medication tried and document failure (include T-score and date, if applicable): Y N

   Documentation supporting failure OR \ Decrease in T-score in comparison with baseline T-score from DEXA scan OR \ New fracture

   [If yes, no further questions.]

10. Did the patient have an intolerance or contraindication to at least one formulary bisphosphonate (for any length of time)? Please list the medication tried and document intolerance or contraindication here: Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date