

**Health New England  
Medication Request Form (MRF) /Prescription Request**

**Reclast® (zolendronic acid)**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

**Prior Authorization**

- Prior Authorization Only**
- Prior Authorization and Drug Delivery Request**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Reclast®. Please complete this form and fax to ICORE Healthcare at (866)-364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

**Medication Request Information (please complete each section of this form prior to transmittal):**

J-Code = J3488; (medication packaged in )

<b>Patient Information (all required)</b>		<b>Physician Information (all required)</b>	
<b>Patient Name:</b>		<b>Physician Name:</b>	
		<b>Specialty:</b>	
<b>Patient Cell Phone #:</b> ( ) -		<b>NPI#:</b>	
<b>Patient HNE ID#:</b>		<b>HNE Provider #:</b>	
<b>Patient Date of Birth:</b>		<b>DEA #:</b>	
<b>Allergies:</b>		<b>Telephone #:</b> ( ) -	
		<b>Fax #:</b> ( ) -	

<b>Drug Information</b>			
<b>Requested Drug/Strength/Form: Reclast®</b>			
<b>Dose, Directions, and length of treatment (please be specific):</b>		<b>Quantity (per month):</b>	<b>Refills:</b>
<input type="checkbox"/> <b>Initial Treatment</b>	<input type="checkbox"/> <b>Retreatment</b>	<b>5 mg IV</b>	<b>1 dose annually</b>
<b>Physician Signature:</b>		<b>Date:</b>	
<b>Indication:</b>			
<input type="checkbox"/> <b>Paget's disease of the bone</b> <input type="checkbox"/> <b>osteoporosis in postmenopausal women</b> <input type="checkbox"/> <b>osteoporosis in men</b> <input type="checkbox"/> <b>treatment and prevention of glucocorticoid-induced osteoporosis</b>			
<b>Documentation of Medical Criteria:</b>			
<input type="checkbox"/> elevations in serum alkaline phosphatase two times or higher the normal limit.. <input type="checkbox"/> Relapsed based on increases in serum alk phos, failure to achieve normal alk phos or appearance of symptoms <input type="checkbox"/> Bone mass density (T-score) of -2.5 or lower <input type="checkbox"/> Intolerance to oral bisphosphonates or failure to achieve adequate response to a 12 month trial <input type="checkbox"/> Recent pathologic fracture or documented severe osteoporosis (T-socre worse than -3.0) <input type="checkbox"/> Diagnosis or chronic medical condition requiring ≥7.5mg oral corticosteroid therapy for 12 months or longer.			
<b>Other Pertinent History (relative or pertaining to this request):</b>			