Medical Coverage Criteria
Reclast® (zoledronic acid IV)

This document contains the most current medical coverage criteria using guidance from experts and approved by the Physicians Plus Pharmacy and Therapeutics Committee. This document remains dynamic and will be updated from time to time as new evidence becomes available reflecting substantive changes in care. The most recent version of the medical coverage criteria can be found at www.pplusic.com.

Warning (see full prescribing information for details)
1. Patients receiving Zometa should not receive Reclast.
2. Must be adequately supplemented with calcium and vitamin D.
3. Osteonecrosis of the jaw has been reported in patients treated with bisphosphonates. All patients should have a routine oral exam by the prescriber prior to treatment.
4. Atypical, low-energy or low trauma fractures of the femoral shaft have been reported in bisphosphonate-treated patients.
5. Do not use in pregnant women

FDA Indications (see full prescribing information for disease specific dosage and administration)

Postmenopausal Osteoporosis
- Treatment and prevention of bone mineral density loss in postmenopausal women with documented osteoporosis.

Osteoporosis in Men
- Treatment increases bone mass in men with osteoporosis.

Glucocorticoid-induced Osteoporosis
- Treatment is indicated when the daily glucocorticosteroid dose equivalent is 7.5mg or higher of prednisone and who are expected to remain on glucocorticosteroids for at least 12 months.

Paget’s Disease (Men or Women)
- Treatment is indicated with Paget’s disease of bone with elevations in serum alkaline phosphatase of two times or higher than the upper limit of normal, or those who are symptomatic or at risk for complications.

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Start Here

Member and Prescriber Information

Member Name: ____________________________
Prescriber Name: _______________________

Prescriber Specialty: ___________________

Member Date of Birth: ____________________
Prescriber Phone: _______________________

Member ID #: __________________________
Prescriber Fax: _________________________

Member PCP Name & Address: _______________
Name & Location of Infusion Center: ___________

Criteria
Complete patient specific and condition specific criteria.
Submit all pages of zoledronic acid intravenous criteria for coverage document.
Diagnosis of non-FDA approved indications require condition specific specialist referral and submission of medical record documentation outlining the treatment and follow-up plan.

Regimen Detail

Current status of patient therapy (check a box)
□ New to zoledronic acid intravenous therapy
□ Continuing zoledronic acid intravenous therapy (start date: _______________

Primary indication being treated:

Drug		Status

Alendronate tablets		□ active		□ discontinued		□ not used
Risedronate tablets		□ active		□ discontinued		□ not used
Ibandronate tablets		□ active		□ discontinued		□ not used
Teriparatide (Forteo)		□ active		□ discontinued		□ not used
Ibandronate (Boniva IV)		□ active		□ discontinued		□ not used
Denosumab (Prolia)		□ active		□ discontinued		□ not used
Etidronate (Didronel)		□ active		□ discontinued		□ not used

Anticipated Start Date: _______________
Stop Date: _______________
Dosing Frequency: _______________

Prescriber Signature: ____________________________ Date: _______________
Prescriber NPI: __________________________

Sign and Date

Mail or Fax this form and clinical documentation using the number below.

Mailing Address
Physicians Plus Insurance Corporation
Attn: Pharmacy Services
P.O. Box 2078
Madison, WI 53701-2078

Physicians Plus Pharmacy Services Fax
(608) 327-0324

Prior Authorization Questions
(608) 260-7803 or (800) 545-5015
www.pplusic.com/providers

P+6082-1212
Condition Specific Criteria
(complete and submit this page, too)

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**Step 1:**
Choose primary condition being treated

**Step 2:**
Select condition criteria that apply

**Step 3:**
Check all treatment criteria that apply

- □ Post-menopausal woman
- □ Male
- □ Chronic glucocorticosteroid use of more than 7.5 mg prednisone equivalents per day
- □ Unable to swallow:
  - Provide details: ______________________
  - ______________________
  - ______________________
- □ BMD, T-score less than -2.0
- □ No uncorrected hypocalcemia

- □ Failed at least three formulary agents (refer to page 1)
  - □ Alendronate
  - □ Risedronate
  - □ Ibandronate
  - □ ______________________

- □ Paget's Disease
- □ Alkaline phosphatase more than 2 times upper limit of age-adjusted normal
- □ Symptomatic:
  - ______________________
  - ______________________
- □ At risk for complication(s):
  - ______________________
  - ______________________

- □ Failed at least one formulary agent (refer to page 1)
  - □ ______________________

Describe in detail the nature of not using listed formulary therapies (supply clinic notes for off-label use)

Remember to sign and date request form before submitting