



SCOTT & WHITE
PRESCRIPTION SERVICES

Phone: (800) 728-7947
 Fax: (254)774-1623

FAX

Date: _____

To: _____

Fax Number: _____

Patient Name: _____

Date of Birth: _____

MRN: _____

Medicare has established limited coverage for Reclast® (Zoledronic Acid). The following information is required to determine Medicare Part B coverage for Reclast®. Please indicate the ICD-9 codes that apply.

731.0 Paget's disease of bone

OR

733.01 Senile Osteoporosis AND

- 530.0 Achalasia and cardiospasm
- 530.20-530.21 Ulcer of esophagus
- 530.3 Stricture and stenosis of the esophagus
- 530.87 Mechanical complication of esophagostomy
- 710.1 Systemic sclerosis
- 995.29 Unspecified adverse effect of other drug, medicinal or biological substance
- V12.79 Personal history of other digestive system disease
- V44.1 Gastrostomy
- V45.72 Acquired absence of intestine (large) (small)
- V45.75 Acquired absence of stomach
- V49.84 Bed confinement status

NOTE: In order to meet Medicare coverage for the treatment of postmenopausal osteoporosis, coverage for Reclast requires documentation of 733.01 Senile Osteoporosis as the primary diagnosis and any of the above noted secondary (dual) diagnoses. In addition, the person must have osteoporosis as evidenced by a spine, hip or pelvis Bone Mineral Density (BMD) T-score less than -2.5 or a low-trauma hip fracture or a 10-year all major osteoporosis-related fracture probability of >20 percent based on the U.S.-adapted World Health Organization (WHO) absolute fracture risk model (FRAX®).

Dexa date: _____ **T-score(s):** _____

Has patient had a history of low-trauma hip fracture? YES NO

Does the patient have a 10-year all major osteoporosis-related fracture probability of >20% based on the World Health Organization (WHO) absolute fracture risk model (FRAX®)? YES NO

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

Physician Signature: _____

Address: _____

Phone: _____ **Fax:** _____

Please complete this prior authorization request and fax to SWHP Prescription Services at 254-774-1623

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