



Reclast – zoledronic acid

Member Information

Name _____
Enrollment / Cardholder ID _____
Group / Plan _____
Birth Date _____
Address _____
City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent
Gender (Circle)
Male Female
AGE: _____

Practitioner Information

Name _____
Agent / Contact Name _____
Specialty _____
Office / Clinic Name _____
Address _____
City State Zip _____
Phone () - _____
Fax () - _____
Email _____ @ _____

**Primary Diagnosis Condition /
Diagnosis Related – Reason for Request**

- List the patient's primary diagnosis: _____
- Is the patient currently receiving calcium and vitamin D supplementation? **Y / N**
- Is the patient at high risk of fracture, osteoarthritis, heart failure, or kidney stones, or does the patient have symptomatic disease? **Y / N**
- If yes, please describe: _____
- Is the patient intolerant to or unable to take oral bisphosphonates? **Y / N**
- Does the patient have a history of a vertebral or hip fracture? **Y / N**
- Femoral neck T-score: _____
- Serum alkaline phosphatase level: _____
- Serum creatinine level: _____ Serum calcium level: _____

Strength / Dose / Frequency

Duration of Therapy (Expected)

**Formulary Alternatives
Attempted/Outcome**

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? Y N

Pharmacy Phone Number

Practitioner Signature

Date Received: _____
Reviewed By: _____
Forwarded To: _____

**FAX Form to
877-800-5633**