Blue Care Network of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Zoledronic Acid Questionnaire

Intravenous bisphosphonate therapy – Zoledronic acid infusion

Blue Care Network provides coverage for the requested medication for adult members who meet approved medical necessity criteria. Submit prior authorization requests through e-referral. The submitter will receive a prompt to complete a questionnaire to determine the appropriateness of the requested service. The questions are listed below. Authorization is not a guarantee of payment. Payment is based on established claim edits. Compliance with this prior authorization service will be monitored retrospectively.

Please note: All requests should be entered as one visit. Requests for more than one visit will pend for further review.

J code	Description
3489	Injection, zoledronic acid, 1 mg
3488	Injection, zoledronic acid (Reclast®), 1 mg (termed 12/31/2013)
3487	Injection, zoledronic acid (Zometa®), 1 mg (termed 12/31/2013)
Q2051	Injection, zoledronic acid, 1 mg (termed 12/31/2013)

1.	If the medication request is for Reclast (zoledronic acid) 5 mg yearly, please answer questions 2-4.	
2.	Has the patient received Reclast (zoledronic acid) in the past?	☐Yes ☐No ☐Unknown
3.	Has the patient had a trial or intolerance to oral bisphosphonate therapy, which includes: Fosamax®, Actonel®, Boniva®, Atelvia®?	☐Yes ☐No
4.	Does the patient have one of the following conditions?	☐Esophageal strictures ☐Achalasia ☐History of gastric bypass ☐Barrett's esophagitis ☐Inability to stand or sit for 30 mins ☐GERD ☐None of the above
5.	If the request is for Zometa (zoledronic acid) 4mg, please answer applicable questions 6-11.	
6.	Has the patient received Zometa (zoledronic acid) in the past?	☐Yes ☐No ☐Unknown
7.	For the requested medication, what is the patient's diagnosis?	☐Bone metastasis from a solid tumor ☐Hypercalcemia of malignancy = Go to Q8 thru Q10 ☐Multiple myeloma ☐Other = Go to Q11
8.	If for hypercalcemia of malignancy, please provide the calcium.	Calcium level = _____mg/dL
9.	If for hypercalcemia of malignancy, please provide the albumin level.	Albumin level = _____g/dL
10.	If for hypercalcemia of malignancy, please provide the date of lab results.	Date of lab results = ___/___/____
11.	If for other, please provide details of diagnosis and dosing for the requested medication (USE THE I-EXCHANGE COMMENTS SECTION).	_____ _____ _____