PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Auryxia® (ferric citrate)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Auryxia 210 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. For a diagnosis of hyperphosphatemia in patients with chronic kidney disease (CKD), must meet all of the following:
   a) Require dialysis to control disease
   b) Must have failed on calcium acetate or sevelamer

2. For a diagnosis of iron-deficiency anemia in CKD, must meet all of the following:
   a) Not be on dialysis
   b) Have eGFR < 60 ml/min
   c) Must have had an inadequate response on therapeutic doses of oral iron supplements
   d) Must have hemoglobin (Hgb) between 9 g/dL and 11.5 g/dL
   e) Must have serum ferritin ≤ 200 ng/mL and transferrin saturation (TSAT) < 25%

Initial approval duration for iron-deficiency anemia in CKD is 4 months. Continued approvals are annual.

For continuation in iron-deficiency anemia after initial 4 month approval, patient must have met the following requirements:

1. Must not require dialysis to control CKD.
2. Must be free of the need for additional therapy with erythropoiesis-stimulating agents (ESA), intravenous iron, or blood transfusions.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2018

Last reviewed 01/2020

PriorityHealth

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Hyperphosphatemia in patients with CKD
- ☐ Iron-deficiency anemia in patients with CKD
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Is the patient receiving dialysis treatment?

- ☐ Yes
- ☐ No

C. Which of the following has the patient tried (please include dose, dates, and outcome)?

- ☐ Calcium acetate
  Dose:_____ Date:_____ Outcome:_____
- ☐ Sevelamer
  Dose:_____ Date:_____ Outcome:_____
- ☐ Oral iron supplements
  Dose:_____ Date:_____ Outcome:_____
- ☐ Other:_____
  Dose:_____ Date:_____ Outcome:_____

D. Please provide baseline hemoglobin: _____ Date: _____

E. Please provide hemoglobin level after treatment with oral iron:_____ Date: _____

F. Please list patient's current laboratory levels:

eGFR: _____Date: _____
Serum ferritin: _____ Date: _____
TSAT: _____ Date: _____

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

a. ☐ Hyperphosphatemia in patients with CKD
b. ☐ Iron-deficiency anemia in patients with CKD
c. ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Is the patient receiving dialysis treatment?

- ☐ Yes
- ☐ No

C. What was hemoglobin prior to starting treatment with Auryxia? _____ Date: _____

D. What is patient's current hemoglobin? _____ Date: _____

E. Has the patient required treatment with an ESA (i.e. Epogen, Procrit), IV iron, or blood transfusion since starting Auryxia?

- ☐ Yes
- ☐ No

Additional information

Initial approval for treatment of iron deficiency anemia will be 4 months authorization. If continuation criteria are met a 1 year authorization can be placed.
Initial approval for hyperphosphatemia will be indefinite authorization.

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Last reviewed 01/2020