

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.

Natpara[®] (parathyroid hormone)

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: Natpara 25 mcg kit **Start date** (or date of next dose): _____
 Natpara 50 mcg kit **Date of last dose** (if applicable): _____
 Natpara 75 mcg kit **Dosing frequency:** _____
 Natpara 100 mcg kit

Drug cost information

The cost of treatment with Natpara is more than \$123,800 each year.

Precertification Requirements

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

1. Patient must have hypoparathyroidism
2. Must provide documentation of serum parathyroid hormone, calcium, magnesium, and phosphate levels (all drawn together)
3. Must be concurrently taking a calcium supplement and a Vitamin D supplement.

Note: Authorization for indications 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 drug's use for the identified indication.

New request
Priority Health Precertification Documentation

A. Has the patient been diagnosed with hypoparathyroidism?

- Yes
 No – the patient’s condition is: _____
 Rationale for use: _____

B. Is the patient taking a calcium and Vitamin D supplement?

- Yes
 No, rationale for use: _____

C. Provide serum parathyroid hormone lab results for two different dates:

Lab Date	Result	Interpretation		
_____	_____ ng/dL	<input type="checkbox"/> high	<input type="checkbox"/> low	<input type="checkbox"/> within normal limits
_____	_____ ng/dL	<input type="checkbox"/> high	<input type="checkbox"/> low	<input type="checkbox"/> within normal limits

D. Provide serum calcium lab results for two different dates:

Lab Date	Result	Interpretation		
_____	_____ ng/dL	<input type="checkbox"/> high	<input type="checkbox"/> low	<input type="checkbox"/> within normal limits
_____	_____ ng/dL	<input type="checkbox"/> high	<input type="checkbox"/> low	<input type="checkbox"/> within normal limits

E. Provide serum magnesium lab results for two different dates:

Lab Date	Result	Interpretation		
_____	_____ ng/dL	<input type="checkbox"/> high	<input type="checkbox"/> low	<input type="checkbox"/> within normal limits
_____	_____ ng/dL	<input type="checkbox"/> high	<input type="checkbox"/> low	<input type="checkbox"/> within normal limits

F. Provide serum phosphate lab results for two different dates:

Lab Date	Result	Interpretation		
_____	_____ ng/dL	<input type="checkbox"/> high	<input type="checkbox"/> low	<input type="checkbox"/> within normal limits
_____	_____ ng/dL	<input type="checkbox"/> high	<input type="checkbox"/> low	<input type="checkbox"/> within normal limits