PriorityHealth®

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial** ☒ **Commercial Individual (PPACA)** ☐ **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.

Parsabiv® (etelcalcetide)

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 and Billing Information

Drug product:
- ☐ Parsabiv 2.5 mg/0.5mL
- ☐ Parsabiv 5 mg/1mL
- ☐ Parsabiv 10 mg/2mL

Start date (or date of next dose): ______________

Date of last dose (if applicable): ______________

Dosing frequency: ______________

Place of administration:
- ☐ Provider's office
- ☐ Outpatient infusion center — Center name: ______________
  Is the outpatient infusion center affiliated with a hospital? ☐ Yes ☐ No
- ☐ Home infusion — Agency name: ______________

Billing:
- ☐ Physician buy and bill
- ☐ Preferred specialty vendor
- ☐ Other: ______________

- ☐ New request
- ☐ Continuation request

ICD code(s): ______________________

Precertification Requirements

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

1. Must be using for a diagnosis of secondary hyperparathyroidism in patients with chronic kidney disease (CKD) on hemodialysis.
2. Must first have a therapeutic trial and failure on Sensipar.

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.

New 01/2018
Last reviewed 01/2018

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Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Secondary hyperparathyroidism in patient with CKD on hemodialysis
- ☐ Other – rationale for use: ____________________

B. Has the patient tried and failed on Sensipar?

- ☐ Yes
  - Dose and dates of use: ____________________
  - Outcome: ____________________
- ☐ No, *rationale*: ____________________

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New 01/2018
Last reviewed 01/2018