PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Rayaldee™ (calcifediol)

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: ______________

Drug information

☐ New request ☐ Continuation request

Drug product: ☐ Rayaldee 30 mcg capsule

Start date (or date of next dose): ______________

Date of last dose (if applicable): ______________

Dosing frequency: ______________

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically-accepted indication* not otherwise excluded from Medicare Part D coverage
2. Must have a serum total 25-hydroxyvitamin D level less than 30 ng/mL (must be submitted to Priority Health)
3. Must have chronic kidney disease (CKD) stage 3 or 4

Additional information

When approved, coverage duration will be for 1 year.

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 03/2018
Last reviewed 03/2019

Priority Health Precertification Documentation

A. What condition is this drug being requested for?
- ☐ Treatment of secondary hyperparathyroidism
- ☐ *Other – the patient's condition is:* ______________________________

B. Does the patient have stage 3 or 4 chronic kidney disease (chronic renal failure)?
- ☐ Yes
- ☐ No. ***Rationale for use:*** ______________________________

C. Does the patient have serum total 25-hydroxyvitamin D levels < 30 ng/mL (must submit to Priority Health)?
- ☐ Yes
- ☐ No. ***Rationale for use:*** ______________________________

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Rayaldee likely be the most effective option for this patient?
- ☐ No
- ☐ Yes, because:______________________________

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If the patient is currently using Rayaldee, would changing the patient's current regimen likely result in adverse effects for the patient?
- ☐ No
- ☐ Yes, because:______________________________

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