Prior Authorization Request Form for Cinacalcet (Sensipar)

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request:	Dx/Dx Code: _____
Member is not receiving other calcimimetics.	☐ Yes ☐ No

☐ If requesting for daily quantity exceeding daily limit, please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

SECONDARY HYPERPARATHYROIDISM:

- ☐ Member has a diagnosis of secondary hyperparathyroidism due to chronic kidney disease (CKD)
- ☐ Member is on dialysis
- ☐ Prescribed by or in consultation with a nephrologist or endocrinologist
- ☐ Lab results over the previous 3-6 months show an increase in iPTH level or current (within last 30 days) labs show iPTH above normal levels:_____
- ☐ Member has failed a vitamin D analog, unless contraindicated or clinically significant adverse effects are experienced
- ☐ Member does not have a serum calcium less than the lower limit of the normal range
- ☐ Dose does not exceed 180mg/day

PARATHYROID CARCINOMA AND PRIMARY HYPERPARATHYROIDISM:

- ☐ Member has a diagnosis of one of the following:
  - ☐ Hypercalcemia due to parathyroid carcinoma
  - ☐ Hypercalcemia due to primary hyperparathyroidism
- ☐ Prescribed by or in consultation with an oncologist, nephrologist or endocrinologist
- ☐ Dose does not exceed 360mg/day

RENEWAL REQUESTS FOR SECONDARY HYPERPARATHYROIDISM:

- ☐ Member has documentation of tolerability and experienced a positive clinical response to requested medication evidenced by a decrease in iPTH:_____
- ☐ Member needs a dose increase (reason for dose increase):_____
- ☐ Dose does not exceed 300mg/day

RENEWAL REQUESTS FOR PARATHYROID CARCINOMA AND PRIMARY HYPERPARATHYROIDISM:

- ☐ Member has documentation of tolerability and experienced a positive clinical response to requested medication evidenced by a decrease in serum calcium:_____
- ☐ Member needs a dose increase (reason for dose increase):_____
- ☐ Dose does not exceed 360mg/day

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :		
Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)