Prior Authorization Request Form for Potassium Removing Agents

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group 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: _____

Requests for non-preferred Potassium Removing Agents: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Xanthine Oxidase Inhibitor? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No *Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____
- ☐ If not prescribed by one of the following specialist cardiologist or nephrologist, please indicate a specialist consulted:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

INITIAL REQUEST:

- ☐ Recent serum potassium levels:_____(submit labs)
- ☐ Documented therapeutic failure of **all** of the following:
  - ☐ A low potassium diet:_____
  - ☐ A loop or thiazide diuretic, if clinically appropriate (medication, start date and end date):_____
  - ☐ Discontinuation or dose reduction to the minimum effective dose of medications known to cause hyperkalemia:_____

RENEWAL REQUEST:

- ☐ Documentation of recent serum potassium levels demonstrating a positive clinical response to therapy:_____ (submit labs)

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: