

## 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

	Prior authorization may be comp	ieleu al iilps.//w	ww.covermymeus.com	11/ 11a11/ p1 101 -auti101 12ati011-101 115/		
I. PR	OVIDER INFORMATION		<b>II. MEMBER INFOR</b>	RMATION		
Prescriber Name:			Member Name:			
Prescriber Specialty:			Identification #:			
NPI:		Group #:				
Office Contact Name:			Date of Birth:			
Fax #:		Medication Allergies:				
Phone	#:					
III. D	RUG INFORMATION (One drug	request per form	1)			
Drug name and strength: Dosage Interval (sig		g):	Qty. per Day:			
	EQUIRED DOCUMENTION (Deta must be submitted with prior at			demonstrating evidence for each		
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:						
SECON	<ul> <li>Prescribed by or in consultation with a nephrologist or endocrinologist</li> <li>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:</li> <li>Member has failed a vitamin D analog, unless contraindicated or clinically significant adverse effects are experienced</li> <li>Member does not have a serum calcium less than the lower limit of the normal range</li> <li>Dose does not exceed 300mg/day</li> </ul>					
	Member needs a dose increase (rea Dose does not exceed 300mg/day VAL REQUESTS FOR PARATHYROI	<b>D CARCINOMA ANI</b> rability and experie calcium:	D PRIMARY HYPERPA enced a positive clinical	RATHYROIDISM: l response to requested medication		

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.)