



Prior Authorization Request Form for Potassium Removing Agents

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.covermyeds.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 DOCUMENTATION (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 Potassium Removing Agent? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.		<input type="checkbox"/> Yes	Medications Tried: _____ _____ _____
		<input type="checkbox"/> No	_____ _____
<input type="checkbox"/> 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: _____			
<input type="checkbox"/> 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:			
<input type="checkbox"/> Recent serum potassium levels: _____			
<input type="checkbox"/> Documented therapeutic failure of all of the following:			
<input type="checkbox"/> A low potassium diet: _____			
<input type="checkbox"/> A loop or thiazide diuretic, if clinically appropriate (medication, start date and end date): _____			
<input type="checkbox"/> Discontinuation or dose reduction to the minimum effective dose of medications known to cause hyperkalemia: _____			
RENEWAL REQUEST:			
<input type="checkbox"/> Documentation of recent serum potassium levels demonstrating a positive clinical response to therapy: _____			
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.)