UnitedHealthcare Community Plan

SENSIPAR

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY☐? If so, start date:_____

Is this patient currently hospitalized? ☐Yes ☐No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION	
Medication:	Strength:
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible):	**ICD-9 CODE:**

Is the patient on dialysis? **YES** **or** **NO** *(circle response)*

Is the patient concurrently receiving traditional therapy with vitamin D sterols and/or phosphate binders?
YES **or** **NO** *(circle response)*

Has the patient had kidney transplantation? **YES** **or** **NO** *(circle response)*

List date of transplantation if available_____

Does the patient have persistent secondary hyperparathyroidism despite kidney transplantation? **YES** **or** **NO** *(circle response)*

What is the patient's serum calcium level? _____

Explanation of why the preferred medication(s) would not meet your patient's needs:

Other Medications tried

Medications, Strength and Directions	Dates of Therapy	Reason for Discontinuation

Physician Signature: _____ **Date:** _____