

# SENSIPAR

## PRIOR AUTHORIZATION REQUEST FORM

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

Today's Date _____		
<b>SECTION A - PATIENT INFORMATION</b>		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:
Is the requested medication <b>NEW</b> <input type="checkbox"/> or a <b>CONTINUATION of THERAPY</b> <input type="checkbox"/> ? If so, start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>SECTION B - PHYSICIAN INFORMATION</b>		
First Name:	Last Name:	M.D./D.O.
Address:	City:	State: Zip:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax Attention to:		
<b>SECTION C - MEDICAL INFORMATION</b>		
Medication:	Strength:	
Directions for use:		
Diagnosis (Please be specific & provide as much information as possible):	ICD-9 CODE:	
Is the patient on dialysis? <b>YES</b> or <b>NO</b> (circle response)		
Is the patient concurrently receiving traditional therapy with vitamin D sterols and/or phosphate binders? <b>YES</b> or <b>NO</b> (circle response)		
Has the patient had kidney transplantation? <b>YES</b> or <b>NO</b> (circle response)		
List date of transplantation if available _____		
Does the patient have persistent secondary hyperparathyroidism despite kidney transplantation? <b>YES</b> or <b>NO</b> (circle response)		
What is the patient's serum calcium level? _____		
Explanation of why the preferred medication(s) would not meet your patient's needs:		
<b>Other Medications tried</b>		
<b>Medications, Strength and Directions</b>	<b>Dates of Therapy</b>	<b>Reason for Discontinuation</b>

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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