

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 <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____ | | | |
| Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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-10 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: _____

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