PA Request Criteria

00-000000000

218123

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 5/13/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: **Patient Phone:** **Physician Name:**
_____ **NPI#:** _____ **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

2. What is the diagnosis?
   - Secondary hyperparathyroidism with chronic kidney disease (CKD) (If checked, go to 3) ☐
   - Primary hyperparathyroidism (If checked, go to 8) ☐
   - Tertiary hyperparathyroidism (If checked, go to 5) ☐
   - Parathyroid carcinoma (If checked, go to 8) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

3. Is the patient currently receiving regular dialysis treatments? **Y** ☐ **N** ☐

4. Has the patient undergone a kidney transplant? **Y** ☐ **N** ☐

5. Has the patient undergone a kidney transplant? **Y** ☐ **N** ☐

6. Is the patient currently receiving regular dialysis treatments? **Y** ☐ **N** ☐

7. Is the patient experiencing benefit from therapy as evidenced by a decrease in intact parathyroid hormone (iPTH) levels from pretreatment baseline? **Y** ☐ **N** ☐

8. Is the patient experiencing benefit from therapy (e.g., decreased or normalized corrected serum calcium levels since starting therapy)? **Y** ☐ **N** ☐

9. What is the diagnosis?
   - Secondary hyperparathyroidism with chronic kidney disease (CKD) (If checked, go to 10) ☐
   - Primary hyperparathyroidism (If checked, go to 12) ☐
   - Tertiary hyperparathyroidism (If checked, go to 13) ☐
   - Parathyroid carcinoma (If checked, go to 15) ☐

Other, please specify. (If checked, no further questions) ☐

_____

10. Is the patient currently receiving regular dialysis treatments? **Y** ☐ **N** ☐

11. Has the patient undergone a kidney transplant? **Y** ☐ **N** ☐

12. Is the patient able to undergo parathyroidectomy? **Y** ☐ **N** ☐

13. Has the patient undergone a kidney transplant? **Y** ☐ **N** ☐

14. Is the patient currently receiving regular dialysis treatments? **Y** ☐ **N** ☐

15. What is the patient's serum calcium level in mg/dL? Indicate in mg/dL.

Any calcium level: please specify in mg/dL (If checked, go to 16) ☐

_____ Unknown (If checked, no further questions) ☐

16. What is the patient's serum albumin level in g/dL? Indicate in g/dL.

Any albumin level: please specify in g/dL (If checked, go to 17) ☐

_____ Unknown (If checked, no further questions) ☐

17. What is the patient's serum calcium level corrected for albumin (i.e., corrected calcium level) in mg/dL? Indicate in mg/dL.

Greater than or equal to 8.4 mg/dL (If checked, no further questions) ☐

Less than 8.4 mg/dL (If checked, no further questions) ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date