SENTARA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: Natpara® (recombinant human parathyroid hormone)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

To be prescribed by an Endocrinologist

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Approval will be for 6 months; then labs to assess patient response to treatment will be required for Continued Approval

- ❑ Patient has diagnosis of hypoparathyroidism as confirmed by parathyroid hormone concentrations below the lower limit of normal on 2 laboratory assays taken at least 21 days apart and performed within the last 12 months **(please attach labs with results)**
- ❑ Diagnosis of hypoparathyroidism has existed for this patient for a minimum of 18 months
- ❑ Patient does **NOT** have a diagnosis of calcium-sensing receptor mutation (CASR mutation) or impaired responsiveness to PTH
- ❑ Patient's albumin-corrected total serum calcium concentration is at least 7.5 mg/dL **(submit current labs to document)**

(Continued on next page)

- ❑ Patient is currently taking a minimum of 0.25mcg calcitriol daily **AND** a minimum of 1000mg calcium daily over and above normal dietary intake
- ❑ Serum magnesium is within normal laboratory limits (submit current labs)
- ❑ Serum 25-hydroxyvitamin D levels are above lower limit of normal of 30ng/mL **(submit current labs)**
- ❑ Patient has serum thyroid function tests within normal laboratory limits **OR** has been stable on thyroid replacement dose for at least 3 months **(submit current labs)**
- ❑ Creatinine clearance >30mL/min on 2 separate occasions **OR** creatinine clearance >60mL/min with serum creatinine <1.5mg/dL **(submit current labs)**

Reauthorization Approval: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Patient has achieved a minimum of 50% reduction of baseline oral calcium dose
- ❑ Patient has achieved a minimum of 50% reduction of baseline calcitriol dose
- ❑ Albumin-corrected total serum calcium is maintained within range of 8.0 - 9.0mg/dL **(please submit current labs)**

Medication being provided by Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*