# SENTARA COMMUNITY PLAN
# (MEDICAID)

## 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 can be delayed.**

**Drug Requested: Rayaldee®** (calcifediol ER)

**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:** _____

**Weight:** _____ **Date:** _____

**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 Authorization: 6 months**

- ❑ Patient is age 18 years or older

**AND**

- ❑ Patient is not on dialysis

**AND**

**(Continued on next page)**

- ❑ Patient is being treated for secondary hyperparathyroidism associated with a diagnosis of chronic kidney disease **{select applicable staging below; attach chart notes and lab work documenting a current glomerular filtration rate (GFR)}**
  - ❑ Stage 3 (30-59 mL/min/1.73m$^2$ eGFR)
  - ❑ Stage 4 (15-29 mL/min/1.73m$^2$ eGFR)

**AND**

- ❑ Total Serum 25-hydroxyvitamin D Level is < 30 ng/mL **(attach most recent lab results to confirm criteria)**

**AND**

- ❑ Plasma iPTH level prior to initiating therapy _____ **(attach most recent lab results to confirm criteria)**

**AND**

- ❑ Albumin corrected calcium level < 9.8 mg/dL within the past 3 months **(attach most recent lab results to confirm criteria)**

**AND**

- ❑ Patient has a trial/failure of the following agent. **(or has a contraindication and/or intolerance – please provide documentation)**:
  - ❑ calcitriol

**Reauthorization Approval: 1 year.** 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 continues to need to be treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease **DOCUMENTED BY A CURRENT GFR**

**AND**

- ❑ Total Serum 25-hydroxyvitamin D Level is 30-100 ng/ml **(attach most recent lab results obtained after first 3 months of treatment)**

**AND**

- ❑ Albumin corrected calcium level is <9.8 mg/dL **(attach most recent lab results obtained after first 3 months of treatment)**

**AND**

- ❑ Serum Phosphorous is <5.5 mg/dL **(attach most recent lab results obtained after first 3 months of treatment)**

**AND**

**(Continued on next page)**

- ❑ Plasma iPTH level remains above treatment goal (below are guideline references): _____ pg/mL
  **(attach most recent lab results obtained after first 3 months of treatment)**

| K/DOQI Guidelines | | KDIGO Guidelines |
|---|---|---|
| Stage 3 | 35-70 pg/mL | 30–68 pg/mL |
| Stage 4 | 70-110 pg/mL | |

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

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



***Approved by Pharmacy and Therapeutics Committee:** 2/15/2018
**REVISED/UPDATED/REFORMATTED:** ~~6/8/2018; 6/19/2019; 10/11/2021;~~ **12/11/2023**