



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Sensipar

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed? Sensipar, Dose: _____ Frequency: _____ Other _____
2. What is the diagnosis?
 Secondary hyperparathyroidism Parathyroid carcinoma
 Primary hyperparathyroidism Other _____
3. What is the ICD-9 code? _____

Complete following Section designated for the patient's diagnosis (Sections: A, B)

SECTION A: Diagnosis Secondary hyperparathyroidism

4. Does the patient have chronic kidney disease? Yes No
5. Is the patient receiving regular dialysis treatments? Yes No
6. **Attach** BASELINE serum calcium corrected for albumin, phosphorous, and iPTH levels
7. What is the serum calcium level? _____ mg/dL
8. Based on patient's serum calcium and phosphorous levels, has the patient had an appropriate trial of phosphate binder? Yes No
9. Has iPTH remained greater than 300 pg/mL with optimal binder therapy? Yes No
10. Has the patient tried vitamin D analogues but failed to reach target iPTH level? Yes No
11. Will the serum calcium, phosphorous, and iPTH levels be monitored during Sensipar therapy?
 Yes No
12. Is the patient currently receiving? Yes No

Only answer the below question(s) if patient is currently receiving Sensipar therapy

13. **Attach** CURRENT serum calcium corrected for albumin, phosphorous, and iPTH levels

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

14. Does the patient have one of the following? Yes (*indicate below*) No
 Serum calcium less than 7.5 mg/dL
 Persistent symptoms of hypocalcemia
 iPTH level less than 150 pg/mL

15. *If Yes*, Will Sensipar dose be reduced or withheld? Yes No

SECTION B: Hypercalcemia of malignancy OR Primary hyperparathyroidism

16. If patient's diagnosis is Primary hyperparathyroidism, is the patient unable to undergo parathyroidectomy? Yes No

17. **Attach** BASELINE serum calcium corrected for albumin level

18. What is the serum calcium level? _____ mg/dL

19. Will the serum calcium level be monitored during therapy? Yes No

20. Is the patient currently receiving Sensipar therapy? Yes No

Only answer the below question(s) if patient is currently receiving Sensipar therapy

21. **Attach** CURRENT serum calcium corrected for albumin level.

22. Does the patient have serum calcium less than 7.5 mg/dL OR persistent symptoms of hypocalcemia?
 Yes No

23. *If Yes*, Will Sensipar dose be reduced or withheld? Yes No

****NOTE: We can NOT make a decision without documentation - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature Date (mm/dd/yy)

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