

AvMed

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 1-305-671-0200.** 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: Natpara[®] (recombinant human parathyroid hormone)

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

Member Name: _____

Member AvMed #: _____ 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: _____

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.