

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



{{PANUMCODE}}

Natpara

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. 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 to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date:** {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the patient's diagnosis?
 Hypocalcemia associated with hypoparathyroidism
 Other _____
2. What is the ICD-10 code? _____
3. Does the patient have acute postsurgical hypoparathyroidism (within 6 months of surgery) and is expected to recover from the hypoparathyroidism? Yes No
4. Is the request for continuation of therapy with the requested medication? Yes No *If No, skip to #6*
5. Is the patient experiencing a benefit from therapy with the requested medication as evidenced by having an increase in calcium and parathyroid hormone level from baseline? Yes No *No further questions*
6. Does the patient have hypocalcemia and concomitant serum parathyroid hormone concentrations below the lower limit of normal for the laboratory reference range on at least 2 separate dates at least 21 days apart within the last 12 months? **ACTION REQUIRED: Please submit supporting laboratory test documentation.** Yes No
7. Is the patient receiving vitamin D metabolite/analog therapy with calcitriol greater than or equal to 0.25 mcg per day or alphacalcidol greater than or equal to 0.5 mcg/day (or equivalent)? Yes No
8. Is the patient receiving supplemental calcium treatment greater than or equal to 1000 mg/day over and above normal dietary calcium intake? Yes No
9. Is the patient's serum magnesium levels within normal laboratory limits? **ACTION REQUIRED: Please submit supporting laboratory test documentation.** Yes No
10. Is the patient's serum 25-hydroxyvitamin D concentration above the lower limit of normal laboratory range? **ACTION REQUIRED: Please submit supporting laboratory test documentation.** Yes No
11. Is the patient's serum calcium is greater than 7.5mg/dL prior to initiating therapy with the requested medication? **ACTION REQUIRED: Please submit supporting laboratory test documentation.** Yes No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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12. Has ALL the following requested documentation been submitted with this request? Yes No
- a) Lab results confirming serum parathyroid hormone concentrations below the lower limit of normal for the laboratory reference range on 2 separate days (at least 21 days apart) within the last 12 months
 - b) Lab results confirming magnesium levels within normal laboratory limits
 - c) Lab results confirming 25-hydroxyvitamin D concentration above the lower limit of normal laboratory range
 - d) Lab results confirming serum calcium is above 7.5mg/dL prior to initiating therapy with the requested medication

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X

Prescriber or Authorized Signature

Date (mm/dd/yy)

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