Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Sensipar (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Sensipar (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Sensipar (cinacalcet)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Does the patient have calcium level of 8.4 to 12.5mg/dL (milligrams per deciliter)? Y N

   [No further questions.]

3. Is this request for secondary hyperparathyroidism due to chronic kidney disease? Y N

[If no, then skip to question 6.]

4. Prior to initiation of therapy, does the patient have a calcium level of at least 8.4mg/dL (milligrams per deciliter) AND an intact parathyroid hormone level of at least 70pg/mL (picograms per milliliter)? Y N

   [If no, then no further questions.]

5. Has the patient had an inadequate response or intolerable side effects to at least one type of Vitamin D analog AND at least one type of phosphate binder? Y N

   [If yes, then skip to question 10.]

   [If no, then no further questions.]

6. Is this request for parathyroid cancer? Y N

   [If yes, then skip to question 9.]

7. Is this request for primary hyperparathyroidism? Y N

   [If no, then no further questions.]

8. Is the patient a surgical candidate? Y N

   [If yes, then no further questions.]

9. Does the patient have a calcium level of at least 12.5mg/dL (milligrams per deciliter) prior to initiation of therapy? Y N

   [If no, then no further questions.]

10. Is the patient 18 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date