

XPHOZAH

PRIOR AUTHORIZATION

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis: <input type="checkbox"/> Chronic kidney disease (CKD) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? Please note, chart notes are required. <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____ _____ 3. Is the patient’s age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is there support for using the requested agent for the patient’s age for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____ _____ 4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., nephrologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). Please note, documentation may be required: _____ _____ _____ _____	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For Chronic kidney disease (CKD) requests:

6. Is the patient on dialysis? Yes No
7. Does the patient have a phosphorus level of at least 5.5 mg/dL? Yes No
8. Will the patient be using phosphate binder therapy in combination with the requested agent? Yes No
 If no, does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to phosphate binder therapy? Yes No
 If yes, please specify intolerance/hypersensitivity or FDA labeled contraindication: _____
9. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No
 If no, has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer?
 Please note, chart notes are required. Yes No
 If yes, please submit chart notes.
 If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No
 If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No

Please use the table to answer the following questions and submit chart notes to support the answers.

<u>Prerequisite generic agent(s)</u>
calcium carbonate
calcium acetate
calcium with magnesium
lanthanum carbonate
sevelamer carbonate
sevelamer HCl

10. Has the patient tried and had an inadequate response to at least ONE prerequisite agent? Yes No
11. Does the patient have an intolerance or hypersensitivity to ONE prerequisite agent? Yes No
12. Does the patient have an FDA labeled contraindication to ALL prerequisite agents? Yes No
13. Was ONE prerequisite agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
14. Is ONE prerequisite agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
15. Is ONE prerequisite agent NOT in the best interest of the patient based on medical necessity? Yes No
16. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE prerequisite agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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Please use the table to answer the following questions and submit chart notes to support the answers.

Preferred agent(s)
Ferric citrate 1 gm (210 mg ferric iron)

17. Has the patient tried and had an inadequate response to the preferred agent? Yes No
18. Does the patient have an intolerance or hypersensitivity to the preferred agent? Yes No
19. Does the patient have an FDA labeled contraindication to the preferred agent? Yes No
20. Was the preferred agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No
21. Is the preferred agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
22. Is the preferred agent NOT in the best interest of the patient based on medical necessity?..... Yes No
23. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the preferred agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

Please fax or mail this form to:
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 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
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BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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