YORVIPATH
PRIOR AUTHORIZATION REQUEST
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 covermymeds.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:

☐ Hypoparathyroidism

☐ 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? ☐ Yes ☐ No
2. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify contraindication(s):____
   ____
3. Is the patient's age within FDA labeling for the requested indication for the requested agent? ☐ Yes ☐ No
   If no, is there support for using the requested agent for the patient's age for the requested indication? ☐ Yes ☐ No
   If yes, please provide supporting information:____
   ____
4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., endocrinologist, nephrologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ☐ Yes ☐ No
5. Will the patient be using the requested agent in combination with denosumab, estrogen, teriparatide, raloxifene, Sensipar (cinacalcet), or Tymlos (abaloparatide) for the requested indication? ☐ Yes ☐ No
6. Does the patient have acute post-surgical hypoparathyroidism? ☐ Yes ☐ No
7. Does the patient have pseudohypoparathyroidism? ☐ Yes ☐ No
8. Is the patient's baseline (prior to therapy with the requested agent) albumin-corrected serum calcium of at least 7.8 mg/dL using calcium and active vitamin D treatment? ☐ Yes ☐ No
9. Does the patient have baseline (prior to therapy with the requested agent) vitamin D levels above the lower limit of normal? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

10. Has the patient tried and had an inadequate response to maximally tolerated calcium AND vitamin D supplements (e.g., calcitriol, ergocalciferol, cholecalciferol)?........ ☐ Yes ☐ No
11. Will the patient continue calcium and vitamin D supplementation while titrating to an appropriate dose of the requested agent? .... ☐ Yes ☐ No
12. 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). ______________________________
____
____
____

For renewal requests:

13. Has the patient had clinical benefit with the requested agent? .... ☐ Yes ☐ No
14. Does the patient have an albumin-corrected total serum calcium concentration between 8.3 to 10.6 mg/dL? .... ☐ Yes ☐ No

Please fax or mail this form to:
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Clinical Review Department
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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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