



Prior Authorization Form

Renvela®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) [ ] Renvela® [ ] Other (specify) \_\_\_\_\_
Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_
Patient Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_
Prescribing Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_
Office Fax #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

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1. DIAGNOSIS FOR DRUG REQUESTED:

- [ ] Chronic Kidney Disease
[ ] Other (specify) \_\_\_\_\_

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

[ ] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug Name, Date, Duration. Includes horizontal lines for data entry.

3. PATIENT HISTORY:

- a. Is the patient currently on dialysis? [ ] Yes [ ] No
b. Has the patient tried and failed or has a contraindication/intolerance/allergy to calcium acetate? [ ] Yes [ ] No
c. Does the patient have hypercalcemia? (corrected serum calcium >10.2mg/dL) [ ] Yes [ ] No
d. Plasma Parathyroid Level (PTH) specify \_\_\_\_\_ pg/ml OR \_\_\_\_\_ pmol/L
e. Does the patient have severe vascular and/or other soft tissue calcification? [ ] Yes [ ] No

Please add any other supporting medical information that may be useful in the decision-making process:

Horizontal lines for additional medical information.

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only
Document # \_\_\_\_\_ Coverage effective date / /
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M F Rx coverage Y N STANDARD - SELECT LOB \_\_\_\_\_
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