{{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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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? ***ACTION REQUIRED: Please submit supporting laboratory test documentation*** ❑ 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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