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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Calcifediol (Rayaldee)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: ______________________	Prescribing physician: ______________________
Patient ID #: ______________________	Physician address: ______________________
Patient DOB: ______________________	Physician phone #: ______________________
Date of Rx: ______________________	Physician fax #: ______________________
Patient phone #: ______________________	Physician specialty: ______________________
Patient email address: ______________________	Physician DEA: ______________________
	Physician NPI #: ______________________
	Physician email address: ______________________

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
	____________	________________	Specify:______________

7. Diagnosis: ____

8. Approval criteria: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient and MAY AFFECT THE OUTCOME of this request.

Prior authorization is required for calcifediol (Rayaldee). Initial requests will be considered for patients when the following criteria are met:

1) Patient is 18 years of age or older; and
2) Patient is being treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease (CKD) as documented by a current glomular filtration rate (GFR); and
3) Patient is not on dialysis; and
4) Patient has a serum total 25-hydroxyvitamin D level less than 30 ng/mL and a serum corrected total calcium below 9.8 mg/dL within the past 3 months; and
5) Patient has documentation of a previous trial and therapy failure at a therapeutic dose with a preferred vitamin D analog for a minimum of 3 months.
6) Initial requests will be considered for a dose of 30 mcg once daily for 3 months.

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Continuation of therapy will be considered when the following criteria are met:

1) Patient continues to need to be treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease (CKD) documented by a current glomular filtration rate (GFR);

   and

2) Patient has a serum total 25-hydroxyvitamin D level between 30 and 100 ng/mL, a serum corrected total calcium below 9.8 mg/dL, and a serum phosphorus below 5.5 mg/dL.

Requests for patients with a diagnosis of stage 5 chronic kidney disease or end-stage renal disease on dialysis will not be considered.

The required trials may be overridden when documented evidence is provided that the use of the agent(s) would be medically contraindicated.

Diagnosis (provide current GFR results): ☐ Stage 3 CKD ☐ Stage 4 CKD

☐ Other: ____

Initial requests:

Document trial of a preferred vitamin D analog:

Drug name & dose:________________________________Trial dates: ______________

Reason for failure: ____

Is patient on dialysis? ☐ Yes ☐ No

Serum total 25-hydroxyvitamin D level (attach results):________________Date obtained: ______________

Serum corrected total calcium level (attach results):________________Date obtained: ______________

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Renewal requests:

Does patient continue to need treatment for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease?

☐ Yes (provide current GFR results) ☐ No

Serum total 25-hydroxyvitamin D level (attach results):________________________Date obtained:_____
____ Serum corrected total calcium level (attach results):____Date obtained :_____
____ Serum phosphorus level (attach results):
____Date obtained:_______________

Attach lab results and other documentation as necessary.

Patient name:_______________________________________ **Patient ID #:** ____________________________

9. Physician signature

____ _______________________________
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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