

**Auryxia (ferric citrate)**  
**Prior Authorization Request Form**  
 Caterpillar Prescription Drug Benefit  
 Phone: 877-228-7909 Fax: 800-424-7640

**MEMBER'S LAST NAME:** \_\_\_\_\_ **MEMBER'S FIRST NAME:** \_\_\_\_\_

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

**URGENT**

MEMBER INFORMATION	
<b>LAST NAME:</b>	<b>FIRST NAME:</b>
<b>PHONE NUMBER:</b>	<b>DATE OF BIRTH:</b>
<b>STREET ADDRESS:</b>	
<b>CITY:</b>	<b>STATE:</b> <b>ZIP CODE:</b>
<b>PATIENT INSURANCE ID NUMBER:</b>	

**MALE**    **FEMALE**   **HEIGHT (IN/CM):** \_\_\_\_\_   **WEIGHT (LB/KG):** \_\_\_\_\_   **ALLERGIES:** \_\_\_\_\_

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [PRIMETHERAPEUTICS.COM/NOPP](http://PRIMETHERAPEUTICS.COM/NOPP)**

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** \_\_\_\_\_  
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** \_\_\_\_\_

PRESCRIBER INFORMATION	
<b>LAST NAME:</b>	<b>FIRST NAME:</b>
<b>PRESCRIBER SPECIALTY:</b>	<b>EMAIL ADDRESS:</b>
<b>NPI NUMBER:</b>	<b>DEA NUMBER:</b>
<b>PHONE NUMBER:</b>	<b>FAX NUMBER:</b>
<b>STREET ADDRESS:</b>	
<b>CITY:</b>	<b>STATE:</b> <b>ZIP CODE:</b>
<b>REQUESTER (if different than prescriber):</b>	<b>OFFICE CONTACT PERSON:</b>

MEDICATION OR MEDICAL DISPENSING INFORMATION			
<b>MEDICATION NAME:</b>			
<b>DOSE/STRENGTH:</b>	<b>FREQUENCY:</b>	<b>LENGTH OF THERAPY/REFILLS:</b>	<b>QUANTITY:</b>
<input type="checkbox"/> <b>NEW THERAPY</b> <input type="checkbox"/> <b>RENEWAL</b>		<b>IF RENEWAL: DATE THERAPY INITIATED:</b>	
<b>DURATION OF THERAPY (SPECIFIC DATES):</b>			

*Continued on next page*



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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?		
<input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY</b> (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Post-gastric bypass surgery <input type="checkbox"/> Stage 3 to 6 chronic kidney disease (CKD)  <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s):		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Is patient going to be using drug in combination with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the requested medication being prescribed by a nephrologist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the patient had a trial and inadequate response or intolerance to calcium acetate tablets or capsules and/or sevelamer carbonate tablets? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the patient have one of the following lab measures? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Calcium and phosphorus product greater than 55mg <sup>2</sup> /dL <sup>2</sup> <input type="checkbox"/> Corrected serum calcium level greater than or equal to 9.5 mg/dL (or maximum per lab facility) and the patient is not being treated with vitamin D <input type="checkbox"/> Parathyroid hormone (PTH) less than 150 pg/ml (or less than 2 times the upper limit of normal) in a patient with corrected calcium levels of 8.4 mg/dL or greater <input type="checkbox"/> Serum phosphorus levels greater than 6.0 mg/dL (or maximum per lab facility) <i>Please provide documentation</i>		
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?  _____  _____		
<b>Please note:</b> Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.		
<b>ATTESTATION:</b> I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.		
<b>Prescriber Signature or Electronic I.D. Verification:</b> _____		<b>Date:</b> _____



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**FAX THIS FORM TO:** 800-424-7640  
**MAIL REQUESTS TO:** Prime Therapeutics Management Prior Authorization Program  
Attn: CP-4201  
P.O. Box 64811  
St. Paul, MN 55164-0811  
**Phone:** 877-228-7909