

Renagel (sevelamer) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

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.

MEMBER INFORMATION LAST NAME: FIRST NAME: PHONE NUMBER: DATE OF BIRTH: STREET ADDRESS: CITY: STATE: ZIP CODE: PATIENT INSURANCE ID NUMBER: MALE FEMALE HEIGHT (IN/CM): WEIGHT (LB/KG): ALLERGIES: PATIENT INSURANCE ID NUMBER: MALE FEMALE HEIGHT (IN/CM): WEIGHT (LB/KG): ALLERGIES: FYOU 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 POLLOWING LUNK: HITPS://MAGELLANDX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/CH-135/PHI DISCLOSURE AUTHORIZATION PDE PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): AUTHORIZATION PDE PATIENT'S AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: FIRST NAME: PRESCRIBER INFORMATION LAST NAME: FIRST NAME: FIRST NAME: PRESCRIBER SPECIALTY: EMAIL ADDRESS: NPI NUMBER: DEA NUMBER: FAX NUMBER: STREET ADDRESS: CITY: STATE: ZIP CODE: PATIENT AUTHORIZATION PRESCRIBER (INFORMATION MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DEFINITION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF QUANTITY: THERAPY/REFILLS: IF RENEWAL: DATE THERAPY (INITIATED: DURATION OF THERAPY (SPECIFIC DATES):		URGENT		
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	DOSE/STRENGTH: FREQUENCY:			
DURATION OF THERAPY (SPECIFIC DATES):	■ NEW THERAPY ■ RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:		
	DURATION OF THERAPY (SPECIFIC DATES):			

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MEMBER'S LAST NAME:

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MEMBER'S FIRST NAME:

1. HAS THE PATIENT TRIED ANY OTH	ER MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO
MEDICATION/THERAPY (SPECIFY	DURATION OF THERAPY (SPECIFY	RESPONSE/REASON FOR
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
□ Post-gastric bypass surgery	_,	
☐ Stage 3 to 6 chronic kidney disease (CK	•	
Other diagnosis:	ICD-10: N: PLEASE PROVIDE ALL RELEVANT CLINICATION N: PLEASE PRO	AL INFORMATION TO SURBORT A
PRIOR AUTHORIZATION.	N: PLEASE PROVIDE ALL RELEVANT CLINICA	AL INFORMATION TO SUPPORT A
Clinical Information:		
Is the requested medication being p	rescribed by a nephrologist?	
□ Yes □ No	rescribed by a frepritologist:	
Has the patient had a trial and inade	quate response or intolerance to calcium	acetate tablets or capsules?
□ Yes □ No		. 400-400 - 40-400-400-400-400-400-400-40
Does the patient have one of the following lab measures?		
□ Yes □ No	•	
Calcium and phosphorus produ	ict greater than 55 mg2/dL2	
Corrected serum calcium level greater than or equal to 9.5 mg/dL (or maximum per lab facility) and the		
patient is not being treat		
 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		
Serum phosphorus levels great	er than 6.0 mg/dL (or maximum per lab fa	acility)
Please provide documentation		
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the		
physician feels is important to this review?		
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-		
	are covered on all plans. This request may	be denied unless all required
information is received.		
ATTESTATION: 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 ac	ccuracy of the information reported on thi	s form.
		_
Prescriber Signature or Electronic I.D		Date:
	ccompanying this transmission contain confidential ereby notified that any disclosure, copying, distribut	
	ou have received this information in error, please no	
and arrange for the return or destruction of t		,, (, (

Magellan Rx MANAGEMENT.



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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811

Magellan Rx MANAGEMENTS