OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Rayaldee®** (calcifediol ER)

DRUG INFORMATON: ***Complete information below. If incomplete, authorization process will be delayed.***

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code**: _____

CLINICAL CRITERIA: ***ALL lines below MUST be completed to qualify. Authorization process will be delayed if incomplete.***

- ❑ Patient is age 18 years or older

AND

- ❑ Patient is not on dialysis

AND

THERAPY PHASE ***(initiation or continuation): Select the applicable response and respond to ALL the following criteria. ALL lines MUST be completed to qualify. Authorization process will be delayed if incomplete. Attach all chart notes and lab results with this request form.***

FOR INITIATION OF THERAPY
(approval for 3 months of therapy of 30mcg once daily)

- ❑ Patient is being treated for secondary hyperparathyroidism associated with a diagnosis of chronic kidney disease ***{select applicable staging below; attach chart notes and lab work documenting a current glomerular filtration rate (GFR)}***
  - ❑ Stage 3 (30-59 mL/min/1.73m^2 eGFR)
  - ❑ Stage 4 (15-29 mL/min/1.73m^2 eGFR)

AND

- ❑ Total Serum 25-hydroxyvitamin D Level is < 30 ng/mL ***(attach most recent lab results to confirm criteria)***

AND

- ❑ Plasma iPTH level prior to initiating therapy _____ ***(attach most recent lab results to confirm criteria)***

AND

- ❑ Albumin corrected calcium level < 9.8 mg/dL within the past 3 months ***(attach most recent lab results to confirm criteria)***

AND

- ❑ Patient has a trial/failure of **TWO (2)** of the following agents. **TRIAL OF BOTH AGENTS *MUST* BE FOR 3-MONTHS EACH** ***(or has a contraindication and/or intolerance – please provide documentation)***:

❑ calcitriol	❑ doxercalciferol	❑ paricalcitol

(continued on next page)

FOR CONTINUATION OF THERAPY
(approval for 12 months of therapy of 60mcg once daily)
Please respond to ALL questions below. Attach ALL lab work to confirm criteria.

- ❑ Patient continues to need to be treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease ***DOCUMENTED BY A CURRENT GFR***

AND

- ❑ Total Serum 25-hydroxyvitamin D Level is 30-100 ng/ml ***(attach most recent lab results obtained after first 3 months of treatment)***

AND

- ❑ Albumin corrected calcium level is <9.8 mg/dL ***(attach most recent lab results obtained after first 3 months of treatment)***

AND

- ❑ Serum Phosphorous is <5.5 mg/dL ***(attach most recent lab results obtained after first 3 months of treatment)***

AND

- ❑ Plasm iPTH level remains above treatment goal (below are guideline references): _____ pg/mL ***(attach most recent lab results obtained after first 3 months of treatment)***

K/DOQI Guidelines		**KDIGO Guidelines**
Stage 3	35-70 pg/mL	30–68 pg/mL
Stage 4	70-110 pg/mL	

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee:** 2/15/2018
REVISED/UPDATED: 6/8/2018