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.***

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 stage below and attach current labs documenting estimated glomerular filtration rate (eGFR)}***
  - ❑ 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 < 30mg/mL ***(attach lab work to confirm criteria)***

AND

- ❑ Plasma iPTH level prior to initiating therapy _____ ***(attach current lab results)***

AND

- ❑ Albumin-corrected total serum calcium below 9.8 mg/dL within the past 3 months ***(attach current lab results)***

AND

- ❑ Patient must have a 90-day trial/failure of **TWO (2)** of the following agents ***(must attach chart notes and labs to document therapy failures)***:

❑ 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 is being treated for secondary hyperparathyroidism associated with a diagnosis of chronic kidney disease ***{select applicable stage below and attach current labs documentation estimated glomerular filtration rate (eGFR)}***
  - ❑ 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 has been maintained between 30-100 ng/mL ***(attach current lab results)***

AND

- ❑ Albumin-corrected total serum calcium is <9.8 mg/dL ***(attach current lab results)***

AND

- ❑ Serum Phosphorous is <5.5 mg/dL ***(attach current lab results)***

AND

- ❑ Plasma iPTH level remains above treatment goal (below are guideline references) _____ ***(attach current lab results)***

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

Medication being provided by (check applicable box below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy**: **PropriumRx**

*****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: 3/31/2018