Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Natpara® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Hypoparathyroidism

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is the patient's diagnosis confirmed by parathyroid hormone (PTH) concentrations below the lower limit of normal on 2 laboratory assays taken at least 21 days apart and performed within the last 12 months? ❑ **Yes** ❑ **No**
Submission of lab results is required

Has the patient's hypoparathyroidism existed for a minimum of 18 months? ❑ **Yes** ❑ **No**

Does the patient have calcium-sensing receptor mutation (CASR mutation)? ❑ **Yes** ❑ **No**

Does the patient have impaired responsiveness to PTH? ❑ **Yes** ❑ **No**

Is the patient's albumin-corrected total serum calcium concentration at least 7.5 mg/dL? ❑ **Yes** ❑ **No**
Submission of current labs is required

Is the patient currently taking a minimum of 0.25mcg calcitriol daily AND a minimum of 1000mg calcium daily over and above normal dietary intake? ❑ **Yes** ❑ **No**

Is the patient's serum magnesium within normal laboratory limits? ❑ **Yes** ❑ **No**
Submission of current labs is required

Are the patient's serum 25-hydroxyvitamin D levels above the lower limit of normal of 30ng/mL? ❑ **Yes** ❑ **No**
Submission of current labs is required

Are the patient's serum thyroid function tests within normal laboratory limits? ❑ **Yes** ❑ **No**
Submission of current labs is required

Has the patient been stable on thyroid replacement dose for at least 3 months? ❑ **Yes** ❑ **No**
Submission of current labs is required

Select if the patient has a creatinine clearance of the following:
- ❑ Greater than 30mL/min on 2 separate occasions
- ❑ Greater than 60 mL/min with serum creatinine less than 1.5mg/dL

Submission of current labs is required

Reauthorization:

If this is a reauthorization request, answer the following questions:

Has the patient achieved a minimum of 50% reduction of baseline oral calcium dose? ❑ **Yes** ❑ **No**

Has the patient achieved a minimum of 50% reduction of baseline calcitriol dose? ❑ **Yes** ❑ **No**

Is the patient's albumin-corrected total serum calcium maintained within range of 8.0-9.0 mg/dL? ❑ **Yes** ❑ **No**
Submission of current labs is required

Natpara® Prior Authorization Request Form (Page 2 of 2)

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Medication being provided by: (Please check applicable box below)

❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.