

**Please print – accuracy is important.**

**Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.**

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for calcifediol (Rayaldee). Initial requests will be considered for patients when the following criteria are met:

1. Patient is 18 years of age or older; and
2. Patient is being treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease (CKD) as documented by a current glomerular filtration rate (GFR); and
3. Patient is not on dialysis; and
4. Patient has a serum total 25-hydroxyvitamin D level less than 30 ng/mL and a serum corrected total calcium below 9.8 mg/dL within the past three months; and
5. Patient has documentation of a previous trial and therapy failure at a therapeutic dose with a preferred vitamin D analog for a minimum of three months.
6. Initial requests will be considered for a dose of 30 mcg once daily for three months.

Continuation of therapy will be considered when the following criteria are met:

1. Patient continues to need to be treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease (CKD) documented by a current glomerular filtration rate (GFR); and
2. Patient has a serum total 25-hydroxyvitamin D level between 30 and 100 ng/mL, a serum corrected total calcium below 9.8 mg/dL, and a serum phosphorus below 5.5 mg/dL.

Requests for patients with a diagnosis of stage 5 chronic kidney disease or end-stage renal disease on dialysis will not be considered.

The required trials may be overridden when documented evidence is provided that the use of the agent(s) would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult [www.iowamedicaidpd.com/pa\\_criteria](http://www.iowamedicaidpd.com/pa_criteria).

**Non-Preferred**

Rayaldee

Strength: \_\_\_\_\_ Dosage instructions: \_\_\_\_\_ Quantity: \_\_\_\_\_ Days supply: \_\_\_\_\_

Diagnosis (provide current GFR results):  Stage 3 CKD  Stage 4 CKD

Other:

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**Initial Requests:**

Document trial of a preferred vitamin D analog:

Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Reason for failure: \_\_\_\_\_

Is patient on dialysis?  Yes  No

Serum total 25-hydroxyvitamin D level (attach results): \_\_\_\_\_ Date obtained: \_\_\_\_\_

Serum corrected total calcium level (attach results): \_\_\_\_\_ Date obtained: \_\_\_\_\_

**Renewal Requests:**

Does patient continue to need treatment for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease?

Yes (provide current GFR results)  No

Serum total 25-hydroxyvitamin D level (attach results): \_\_\_\_\_ Date obtained: \_\_\_\_\_

Serum corrected total calcium level (attach results): \_\_\_\_\_ Date obtained: \_\_\_\_\_

Serum phosphorus level (attach results): \_\_\_\_\_ Date obtained: \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Prescriber signature: (Must match prescriber listed above.)	Date of submission:
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Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check [www.amerihealthcaritasia.com/Provider](http://www.amerihealthcaritasia.com/Provider) to confirm your version of this form.