

RENVELA

PRIOR AUTHORIZATION REQUEST

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date: _____			
SECTION A - PATIENT INFORMATION			
First Name:		Last Name:	
Address:		Member ID:	
City:		State:	Zip:
Phone:		DOB:	Allergies:
Primary Insurance:		Policy #:	Group #:
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
SECTION B - PHYSICIAN INFORMATION			
First Name:		Last Name: M.D./D.O.	
Address:		City:	State: Zip:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to: _____			
SECTION C - MEDICAL INFORMATION			
Medication:	Strength:	Dosing frequency:	
Directions for use: _____			
Diagnosis (Please be specific & provide as much information as possible):			ICD-10 CODE:
Is this medication being prescribed to control serum phosphorus in patients with chronic kidney disease on dialysis? Yes ___ No ___			
Has the patient tried and failed therapy with calcium acetate? Yes ___ No ___			
Length of therapy _____			
Did the patient exhibit an <u>inadequate response/ intolerance/adverse reaction</u> or <u>contraindication</u> to treatment with calcium acetate as evidenced by a phosphorus level >5.5mg/dl while on calcium acetate therapy? Yes ___ No ___			
List reaction / side effect / contraindication: _____			

Physician Signature: _____ **Date:** _____

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