UnitedHealthcare Community Plan

RENVELA
PRIOR AUTHORIZATION REQUEST

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

Today's Date:		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY☐? If so, start date:_____

Is this patient currently hospitalized? ☐Yes ☐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: _____