Parsabiv™ (etelcalcetide) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: ________________ Phone: ________ Fax: ________

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: ________ lbs or ________ kgs   Height: ________ inches or ________ cms

B. INSURANCE INFORMATION

Aetna Member ID #: ________________
Group #: ________________
Insured: ________________

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ________ Carrier Name: ________
Insured: ________________

Medicare: ☐ Yes ☐ No If yes, provide ID #: ________ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: ________

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:	City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Orthopedic** ☐ **Other**: ________________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ________
Center Name: ________
☐ Home Infusion Center Phone: ________
Agency Name: ________
☐ Administration code(s) (CPT): ________
Address: ________

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: ________
Name: ________
Address: ________
Phone: ________ Fax: ________
TIN: ________ PIN: ________

E. PRODUCT INFORMATION

Request is for Parsabiv (etelcalcetide): Dose: ________ **Frequency:** ________

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: ________ Secondary ICD Code: ________ Other ICD Code: ________

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests: (clinical documentation required for all requests)

☐ Yes ☐ No Does the patient have a diagnosis of secondary hyperparathyroidism with chronic kidney disease?
☐ Yes ☐ No Is the patient currently receiving regular dialysis treatments?

For Initiation requests:

Chronic kidney disease

What is the patient's serum calcium level in mg/dl? ____
What is the patient's serum albumin level in g/dl? ____
What is the patient's serum calcium level corrected for albumin (i.e., corrected calcium level) in mg/dl? ____

☐ Yes ☐ No Has the patient had a therapeutic failure or insufficient response to two phosphate binders?
→ (No) ☐ Yes ☐ No Does the patient have a contraindication or intolerance to two phosphate binders?
→ Please select: ☐ contraindication ☐ intolerance
→ (Yes) Please select: ☐ therapeutic failure ☐ insufficient response
☐ Yes ☐ No Did the patient have a 2-month trial of each phosphate binder?
→ Please select which of the following phosphate binders the patient tried:

Select all that apply: ☐ Fosrenol (lanthanum carbonate) ☐ PhosLo (calcium acetate)
☐ Renagel (sevelamer hydrochloride) ☐ Renvela (sevelamer carbonate)
☐ Other: Please identify: ________

Phosphate binder #1 Date range: ____/____/____ to ____/____/____
Phosphate binder #2 Date range: ____/____/____ to ____/____/____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Has the patient had a therapeutic failure or insufficient response to at least two vitamin D analogs?
- (No) → ☐ Yes ☐ No Does the patient have a contraindication or intolerance to two vitamin D analogs?
  - → Please select: ☐ contraindication ☐ intolerance
- (Yes) → Please select: ☐ therapeutic failure ☐ insufficient response
  - ☐ Yes ☐ No Did the patient have a 2-month trial of each vitamin D analog?
    - → Please select which of the following vitamin D analogs the patient tried:
      Select all that apply: ☐ Calcijex (calcitriol) ☐ Hectorol (doxercalciferol) ☐ Zemplar (paricalcitol)
      ☐ Other: Please identify: ____________________
      Vitamin D analog #1 Date range: ___/___/___ to ___/___/___
      Vitamin D analog #2 Date range: ___/___/___ to ___/___/___

☐ Yes ☐ No Has the patient had a therapeutic failure to Sensipar (cinacalcet)?
- (No) → ☐ Yes ☐ No Does the patient have a contraindication or intolerance to Sensipar (cinacalcet)?
- (Yes) → ☐ Yes ☐ No Is there documentation the patient completed a 6 month trial of Sensipar (cinacalcet)?
  - Please enter date range: ___/___/___ to ___/___/___
  - ☐ Yes ☐ No Was the duration of the medication trial at the maximum tolerated dose?

For Continuation Requests:

☐ Yes ☐ No Has the patient received samples of Parsabiv? (Sampling of Parsabiv does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Is the patient experiencing benefit from therapy as evidenced by a decrease in intact parathyroid hormone levels from pretreatment baseline?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* ______________________________ **Date:** ___/___/___

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.