JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

**FAX Completed Form and Applicable Progress Notes to: (410) 424-4037**

# USFHP Pharmacy Prior Authorization Form

| To be completed by Requesting provider | |
|---|---|
| Drug Name: | Strength: |
| Dosage/Frequency (SIG): | Duration of Therapy: |

***Questions?*** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

**Prior authorization does not expire.**

## Step 1

**Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________
Address: ______________________ Address: ______________________
______________________ ______________________
Sponsor ID # ______________________ Phone #: ______________________
Date of Birth: Secure Fax #:

## Step 2

**Please complete the clinical assessment:**

| Question | | |
|---|---|---|
| **1. Is the patient 18 years of age or older?** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. Is the requested medication prescribed by or in consultation with a nephrologist?** | ☐ Yes<br>Proceed to question **3** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3. What is the indication or diagnosis?**<br>Note: Non-FDA approved uses are NOT approved, including constipation-predominant irritable bowel syndrome (IBS-C). | ☐ Hyperphosphatemia in chronic kidney disease (CKD) - Proceed to question **4**<br>☐ Other – **STOP Coverage not approved** | |
| **4. Has the patient been receiving maintenance dialysis for at least 3 months?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5. Is the patient's serum phosphate level greater than 5.5. mg/dL and less than 10 mg/dL?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **6. Has the patient tried and had an inadequate response to at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenol), ferric citrate (Auryxia), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate)?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>Proceed to question **7** |

| | | |
|---|---|---|
| 7. **Has the patient tried and been unable to tolerate at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenol), ferric citrate (Auryxia), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate)?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>Proceed to question **8** |
| 8. **Does the patient have a contraindication to at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenol), ferric citrate (Auryxia), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate). Contraindications to phosphate binders includes bowel obstruction, iron overload, or hypercalcemia?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>Proceed to question **9** |
| 9. **Has the patient had intolerance to any dose of phosphate binder therapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3** **I certify the above is true to the best of my knowledge.** Please sign and date:

______________________________ ____________
Prescriber Signature Date

[8 May 2024]

| **For Internal Use Only** | |
|---|---|
| ☐ Approved: | Duration of Approval: _____month(s) |
| ☐ Denied: | Authorized By: |
| ☐ Incomplete/Other: | PA#: |
| Date Faxed to MD: | Date Decision Rendered: |