

## PHOSPHATE BINDERS PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this form. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Phosphate Binders, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Phosphate Binders** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to **Quantity Limits / Daily Dose Limits** at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	# of pages in request: _____	Prescriber name:		
Name of office contact:			Specialty:		
Contact's phone number:			State license #:		
LTC facility contact/phone:			NPI:	MA Provider ID#:	
RECIPIENT INFORMATION			Street address:		
Recipient Name:			Suite #:	City/state/zip:	
Recipient ID#:	DOB:	Phone:	Fax:		

### CLINICAL INFORMATION

<b>Non-preferred medication requested:</b>			
<input type="checkbox"/> Auryxia tablet	<input type="checkbox"/> Fosrenol powder packet	<input type="checkbox"/> Renvela powder packet	
<input type="checkbox"/> calcium acetate capsule	<input type="checkbox"/> PhosLo capsule	<input type="checkbox"/> sevelamer carbonate tablet	
<input type="checkbox"/> Eliphos tablet	<input type="checkbox"/> Phoslyra solution	<input type="checkbox"/> Velphoro chewable tablet	
<input type="checkbox"/> Fosrenol chewable tablet			
Strength:	Directions:	Quantity:	Refills:
Diagnosis ( <u>submit documentation</u> ):		DX code ( <u>required</u> ):	
1. Has the Recipient tried and failed any of the preferred Phosphate Binders? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <u>submit all supporting documentation of drug regimen and therapeutic failure</u> <input type="checkbox"/> No	
<input type="checkbox"/> calcium acetate tablet <input type="checkbox"/> Renagel tablet <input type="checkbox"/> Renvela tablet			
2. Does the Recipient have any contraindications or intolerances to any of the preferred agents listed in question (1)?		<input type="checkbox"/> Yes – <u>submit all supporting documentation of medication name(s) and associated intolerances and contraindications</u> <input type="checkbox"/> No	

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

Prescriber Signature:	Date:
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