aetna®

rhPTH 1-84 (Natpara®) Injectable Medication Precertification Request

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

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

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:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	E-mail:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms		Allergies:	

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 E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ Endocrinologist ☐ **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): _____

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

E. PRODUCT INFORMATION

Request is for Natpara: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ _____ ☐ Additional ICD code (s): _____

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

☐ Yes ☐ No Does the patient have hypoparathyroidism that is not well controlled on calcium and active forms of vitamin D?
☐ Yes ☐ No Has the patient been diagnosed with hypocalcemia due to hypoparathyroidism?
☐ Yes ☐ No Is the patient currently taking an active form of vitamin D (i.e. calcitriol) and calcium?
☐ Yes ☐ No Does the patient have documented biochemical evidence of hypocalcemia and concomitant serum intact parathyroid hormone (PTH) concentrations below the lower limit of the normal laboratory reference range on 2 test dates at least 21 days apart within the past 12 months?
→ Please enter the two dates: ____/____/____ and ____/____/____
☐ Yes ☐ No Has the patient had a history of hypoparathoidism for at least 18 months?
☐ Yes ☐ No Does the patient have a history of hypoparathyroidism resulting from an activating mutation in the CaSR gene or impaired responsiveness to PTH (pseudohypoparathyroidism)?
☐ Yes ☐ No Does the patient have a known disease that might increase the risk of osteosarcoma such as Paget's disease, children and young adults less than 25 years of age with open epiphyses*, persons with prior history of external beam or implant radiation involving the skeleton, or persons with hereditary syndromes predisposed to osteosarcoma? (e.g.:Li-Fraumeni syndrome, hereditary retinoblastoma, Rothmund-Thomson syndrome type 2, Werner syndrome, Bloom syndrome, RAPADILINO syndrome, and Diamond Blackfan anemia)
X-rays should document epiphyseal closure.
☐ Yes ☐ No Does the patient require vitamin D metabolite/ analog therapy with calcitriol ≥ 0.25 µg per day or alphacalcidol ≥ 0.50 µg per day?
☐ Yes ☐ No Does the patient require supplemental oral calcium ≥ 1000 mg per day over and above normal dietary calcium intake?
☐ Yes ☐ No Are the serum thyroid function tests within normal laboratory limits for patients not on thyroid replacement?
☐ Yes ☐ No ☐ N/A For those patients on thyroid replacement, has the dose of thyroid replacement been stable for at least 3 months? (for persons on thyroid replacement, thyroxine may be outside of reference range but dose of thyroid replacement should be stable at least 3 months)
☐ Yes ☐ No Does the patient have serum magnesium levels within laboratory normal limits?
☐ Yes ☐ No Is the patient's serum 25-hydroxyvitamin D concentration above the lower limit of the normal laboratory reference range?
☐ Yes ☐ No Does the patient have a creatinine clearance > 30 mL/ min on two separate measurements or a creatinine clearance > 60 mL/min AND serum creatinine <1.5 mg/dL?

Continuation of therapy:
☐ Yes ☐ No Does the patient have any signs or symptoms of osteosarcoma?
☐ Yes ☐ No Has the patient developed any risk factors of osteosarcoma since the last authorization?
☐ Yes ☐ No Has the patient had an adequate response to previous Natpara therapy?

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.