aetna®

Parsabiv™ (etelcalcetide) 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

For Medicare Advantage Part B:
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 ☐ Mail Order
☐ 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 Will Parsabiv (etelcalcetide) be used concomitantly with Sensipar (cinacalcet)?
☐ Yes ☐ No Is the patient currently on hemodialysis?
☐ Yes ☐ No Is there documentation an intact plasma parathyroid hormone (PTH) level was completed?
→ Please indicate the intact plasma parathyroid hormone (PTH) level: _____pg/ml Date: ____/____/____

☐ **Chronic kidney disease**
☐ Yes ☐ No Does the patient have a documented diagnosis of secondary hyperparathyroidism?
☐ Yes ☐ No Is there documentation a corrected calcium level has been completed?
→ Please indicate level: _____mg/dl Date: ____/____/____
☐ Yes ☐ No Has the patient had a therapeutic failure/insufficient response or intolerance to two phosphate binders?
→ Please select: ☐ therapeutic failure/insufficient response ☐ intolerance
☐ Yes ☐ No Is there documentation that a trial of two phosphate binders was completed?
→ 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 ____/____/____
☐ Yes ☐ No Does the patient have a contraindication to two phosphate binders?

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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.

☐ **Chronic kidney disease**

☐ Yes ☐ No Has the patient had a therapeutic failure/insufficient response or intolerance to at least two vitamin D analogs?
→ Please select: ☐ therapeutic failure/insufficient response ☐ intolerance
☐ Yes ☐ No Is there documentation that a trial of two vitamin D analogs was completed?
→ 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 Does the patient have a contraindication to two vitamin D analogs?

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

☐ Yes ☐ No Does the patient have a contraindication to Sensipar (cinacalcet)?

☐ Yes ☐ No Is this request for Parsabiv (etelcalcetide) within 7 days of discontinuing Sensipar (cinacalcet)?

For Continuation Requests:

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

☐ Yes ☐ No Is there documentation a phosphate level was completed?
→ Please indicate the phosphate level: _____mg/dL or mmol/L Date: ___/___/___

☐ Yes ☐ No Is there documentation a corrected serum calcium level was completed?
→ Please indicate the corrected serum calcium level: _____mg/dL or mmol/L Date: ___/___/___

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.