

**State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
SENSIPAR**

Phone: 1-888-445-0497

ONE Drug Per Form ONLY – Use Black or Blue Ink

Fax: 1-888-879-6938

Member ID #: _____ <small>(NOT MEDICARE NUMBER)</small>	Patient Name: _____	DOB: _____
Patient Address: _____		
Provider DEA: _____	Provider NPI: _____	
Provider Name: _____		Phone: _____
Provider Address: _____		Fax: _____
Pharmacy Name: _____	Rx Address: _____	Rx phone: _____
Provider must fill all information above. It must be legible, correct and complete or form will be returned.		
(Pharmacy use only): NPI: _____ NABP: _____ NDC: _____		

<u>Drug Name</u>	<u>Strength</u>	<u>Dosage</u> <u>Instructions</u>	<u>Quantity</u>	<u>Days Supply</u> <small>(34 retail / 90 mail order)</small>	<u>Refills</u>
SENSIPAR	_____	_____	_____	_____	1 2 3 4 5

Medical Necessity Documentation Required: (Attach copies of supporting office notes.)

INDICATION:

- Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis
- OR--**
- Parathyroid carcinoma

REQUIREMENTS (for secondary hyperparathyroidism patients with CKD on dialysis):

1. iPTH >400 pg/ml³
2. Corrected serum calcium ≥8.4 mg/dl
3. Calcium X phosphorous product >55 mg²/dl²
4. Treatment failure with calcium based phosphate binders at maximum doses **and** addition or change to non-calcium based phosphate binders at maximum doses
5. Treatment failure with vitamin D/vitamin D analogs

Baseline levels are required and approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Lab results submitted should be dated (most recent) and should include reference ranges.

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care; such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records. Pursuant to Maine State Services manual, Section 2, Maine Drugs for the Elderly Benefit.

Provider Signature: _____ Date of Submission: _____

*MUST MATCH PROVIDER LISTED ABOVE