Natpara® (parathyroid hormone) Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 **(TTY:** 711**)**
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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): _____
Address: _____

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

E. PRODUCT INFORMATION

Request is for: Natpara (parathyroid hormone) 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):

☐ Yes ☐ No Does the patient have a diagnosis of hypocalcemia associated with hypoparathyroidism?
☐ Yes ☐ No Does the patient have acute postsurgical hypoparathyroidism (within 6 months of surgery) and is expected to recover from the hypoparathyroidism?

For Initiation Requests (clinical documentation required including lab work):

☐ Yes ☐ No Does the patient have hypocalcemia and concomitant serum parathyroid hormone concentrations below the lower limit of normal for the laboratory reference range on at least 2 separate dates at least 21 days apart within the last 12 months?
☐ Yes ☐ No Is the patient receiving vitamin D metabolite/analog therapy with calcitriol greater than or equal to 0.25 mcg per day or alfacalcidol greater than or equal to 0.5 mcg/day (or equivalent)?
☐ Yes ☐ No Is the patient receiving supplemental calcium treatment greater than or equal to 1000 mg/day over and above normal dietary calcium intake?
☐ Yes ☐ No Are the patient's serum magnesium levels within normal laboratory limits?
☐ Yes ☐ No Is the patient's serum 25-hydroxyvitamin D concentration above the lower limit of normal laboratory range?
☐ Yes ☐ No Is the patient's serum calcium level greater than 7.5 mg/dL prior to initiating therapy with the requested medication?

For Continuation Requests (clinical documentation required including lab work):

☐ Yes ☐ No Is the patient experiencing a benefit from therapy with the requested medication as evidenced by maintenance or normalization of calcium levels compared to baseline?

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.