Parsabiv® (etelcalcetide) 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:		
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 ☐ 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):

☐ Yes ☐ No Does the patient have a diagnosis of secondary hyperparathyroidism with chronic kidney disease?
☐ Yes ☐ No Is the patient currently receiving regular dialysis treatments?

For Initiation Requests (clinical documentation required):

What is the patient's serum calcium level in mg/dL? _____
What is the patient's serum albumin level in g/dL? _____
What is the patient's serum calcium level corrected for albumin (i.e., corrected calcium level) in mg/dL? _____

☐ Yes ☐ No Did the patient have a therapeutic failure or insufficient response to at least two phosphate binders (e.g., PhosLo, Fosrenol, Renvela, Renagel)?
→ ☐ Yes ☐ No Did the patient have a contraindication or intolerance to at least two phosphate binders?
→ Please select: ☐ contraindication ☐ intolerance

→ Please select: ☐ therapeutic failure ☐ insufficient response

☐ Yes ☐ No Did the patient have at least a 2-month trial of each phosphate binder (e.g., PhosLo, Fosrenol, Renvela, Renagel)?
→ 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 ____/____/____

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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.

☐ Yes ☐ No Did the patient have a therapeutic failure or insufficient response to at least two vitamin D analogs (e.g., calcitriol, Hectorol [doxercalciferol], Zemplar [paricalcitol]?

- ☐ Yes ☐ No Does the patient have a contraindication or intolerance to two vitamin D analogs?
  - Please select: ☐ contraindication ☐ intolerance

Please select: ☐ therapeutic failure ☐ insufficient response

- ☐ Yes ☐ No Did the patient have a 2-month trial of each vitamin D analog (e.g., calcitriol, Hectorol [doxercalciferol], Zemplar [paricalcitol]?
  - Please select which of the following vitamin D analogs the patient tried:
    Select all that apply: ☐ calcitriol ☐ Hectorol (doxercalciferol) ☐ Zemplar (paricalcitol)
    ☐ Other: Please identify: _____
    Vitamin D analog #1 Date range: ____/____/____ to ____/____/____
    Vitamin D analog #2 Date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Has the patient had a therapeutic failure or insufficient response to Sensipar (cinacalcet)?

- ☐ Yes ☐ No Does the patient have a contraindication or intolerance to Sensipar (cinacalcet)?
- ☐ Yes ☐ No Did the patient have at least a 6-month trial of Sensipar (cinacalcet) at the maximum tolerated dose?
  Please enter date range: ____/____/____ to ____/____/____

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Is the patient experiencing benefit from therapy as evidenced by a decrease in intact parathyroid hormone (iPTH) levels from pretreatment 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.