AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Rayaldee® (calcifediol ER)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Patient is age 18 years or older

AND

- ❑ Patient is not on dialysis

AND

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- ❑ Patient is being treated for secondary hyperparathyroidism associated with a diagnosis of chronic kidney disease **{select applicable staging below; attach chart notes and lab work documenting a current glomerular filtration rate (GFR)}**
  - ❑ Stage 3 (30-59 mL/min/1.73m^2 eGFR)
  - ❑ Stage 4 (15-29 mL/min/1.73m^2 eGFR)

AND

- ❑ Total Serum 25-hydroxyvitamin D Level is < 30 ng/mL **(attach most recent lab results to confirm criteria)**

AND

- ❑ Plasma iPTH level prior to initiating therapy _____ **(attach most recent lab results to confirm criteria)**

AND

- ❑ Albumin corrected calcium level < 9.8 mg/dL within the past 3 months **(attach most recent lab results to confirm criteria)**

AND

- ❑ Patient has a trial/failure of **TWO (2)** of the following agents. **TRIAL OF BOTH AGENTS MUST BE FOR 3-MONTHS EACH (or has a contraindication and/or intolerance – please provide documentation)**:
  - ❑ calcitriol
  - ❑ doxercalciferol
  - ❑ paricalcitol

Reauthorization Approval: 1 year. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Patient continues to need to be treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease **DOCUMENTED BY A CURRENT GFR**

AND

- ❑ Total Serum 25-hydroxyvitamin D Level is 30-100 ng/ml **(attach most recent lab results obtained after first 3 months of treatment)**

AND

- ❑ Albumin corrected calcium level is <9.8 mg/dL **(attach most recent lab results obtained after first 3 months of treatment)**

AND

- ❑ Serum Phosphorous is <5.5 mg/dL **(attach most recent lab results obtained after first 3 months of treatment)**

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AND

- ❑ Plasm iPTH level remains above treatment goal (below are guideline references): _____ pg/mL
  (attach most recent lab results obtained after first 3 months of treatment)

K/DOQI Guidelines		KDIGO Guidelines
Stage 3	35-70 pg/mL	30–68 pg/mL
Stage 4	70-110 pg/mL	

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pha rmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** 2/15/2018
REVISED/UPDATED: ~~6/8/2018; (Reformatted) 6/19/2019. 10/11/2021;~~ **10/30/2023**