Updated: 09/2023
DMMA Approved: 09/2023

Request for Prior Authorization for Phosphate Binders
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Phosphate Binders require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Phosphate Binders Prior Authorization Criteria:

Coverage may be provided with a diagnosis of chronic kidney disease and the following criteria is met:

- Must provide documentation of stage 3, 4, or 5 disease
- Must provide documentation of inadequate control of phosphate levels defined as at least two consecutive laboratory phosphate values above the upper limit of normal reference range
- Member must be currently restricting their dietary phosphate intake
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or unable to use a calcium containing phosphate binder
    - Inability to use a calcium containing phosphate binder is constituted by a corrected calcium level of >9.5 mg/dL
- If the patient will be concurrently taking a calcium-based phosphate binder, dietary calcium must be restricted to 2,000 mg (including calcium from calcium-based phosphate binders)
- If the request is for a non-solid dosage form, the individual must be unable to swallow tablets/capsules
- Requests for non-preferred agents will only be approved once the patient has failed a preferred calcium containing phosphate binder and a preferred non-calcium containing phosphate binder
- Requests for concurrent use of two or more non-calcium containing phosphate binders will be denied
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Must provide documentation of an improvement in member's phosphate level from baseline
    - If a non-solid dosage form is still requested, an ongoing rationale must be provided for the patient's inability to swallow tablets/capsules.
- **Reauthorization Duration of Approval:** 12 months

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Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

HIGHMARK HEALTH OPTIONS

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PHOSPHATE BINDERS
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: Chronic Kidney Disease Stage III ☐ Stage IV ☐ Stage V ☐ Other:

Is the member currently on a phosphate restricted diet? Yes ☐ No ☐
Is the member currently on a calcium containing phosphorus binder? Yes ☐ No ☐
If the above answer was yes, is the patient's calcium intake restricted to 2,000 mg? (including calcium from calcium-based phosphate binders) Yes ☐ No ☐
Is the member currently on a non-calcium containing phosphorus binder? (If yes, include in next section) Yes ☐ No ☐

If requesting a non-solid dosage form, provide your rationale for why member cannot take a solid dosage form (e.g. tablet):

_____
_____
_____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

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PHOSPHATE BINDERS
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

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MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

LABORATORY VALUES

	Initial Patient Level*	**Date**	**Second Patient Level***	**Date**	**Post-Therapy Patient Level* (for reauthorization only)**
Phosphorous					
Corrected Calcium					

***Please provide lab reference range (or ranges if different):**

REAUTHORIZATION

If requesting a non-solid dosage form, provide your rationale for why member cannot take a solid dosage form (e.g. tablet):

_____

_____

_____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date