



Updated: 09/2022
DMMA Approved: 09/2022

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.

**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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Billing Information

This medication will be billed: <input type="checkbox"/> at a pharmacy OR <input type="checkbox"/> medically (if medically please provide a JCODE: _____)	
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> 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

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