Updated: 09/2024
DMMA Approved: 09/2024

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

All requests for Cinacalcet require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Cinacalcet Prior Authorization Criteria:

For all requests for Cinacalcet all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- The member is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Documentation serum calcium is greater than the upper limit of the normal range (reference range must be provided)

Coverage may be provided with a diagnosis of hypercalcemia due to primary hyperparathyroidism and the following criteria is met:

- Documentation the member failed or has contraindications to a parathyroidectomy

Coverage may be provided with a diagnosis of secondary hyperparathyroidism and the following criteria is met:

- Documentation the member has chronic kidney disease (CKD) and is on dialysis
- Documentation the member has tried and failed or has a contraindication to both of the following agents:
    - Calcitriol
    - A preferred phosphate binder (please note these may require a prior authorization)

Coverage may be provided with a diagnosis of hypercalcemia in members with parathyroid carcinoma

- **Initial Duration of approval:** 12 months
- **Reauthorization Criteria**
    - Documentation of a reduction in serum calcium from baseline
    - Documentation serum calcium is greater than the lower limit of the

normal range (reference range must be provided)

- **Reauthorization Duration of Approval:** 12 months

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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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CINACALCET
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 am to 7 pm

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: ☐ Hypercalcemia due to primary hyperparathyroidism ☐ Secondary hyperparathyroidism
☐ Hypercalcemia due to parathyroid carcinoma ☐ Other_____

For hypercalcemia due to primary hyperparathyroidism
Please provide the following:
Documentation of a serum calcium level please give reference range: _____ Date taken: _____
Has the member tried and failed or have a contraindication to a parathyroidectomy? ☐ Yes ☐ No

For secondary hyperparathyroidism
Is the member on dialysis? ☐ Yes ☐ No
Please provide the following:
Documentation of a serum calcium level please give reference range: _____ Date taken: _____

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Member Name: **DOB:**
Member ID:

For Hypercalcemia due to parathyroid carcinoma

Please provide the following:
Documentation of a serum calcium level please give reference range: _____ Date taken: _____

CURRENT or PREVIOUS THERAPY			
Medication Name	**Strength/ Frequency**	**Dates of Therapy**	**Status (Discontinued & Why/Current)**

Please provide documentation of a current serum calcium level please give reference range: _____
Date taken: _____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date