



Prior Authorization Form

Renvela®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) [] Renvela® [] Other (specify) _____
Date: _____ Patient ID#: _____ DOB: _____
Patient Name: _____ Provider NPI: _____
Prescribing Physician: _____ Office Contact: _____
Office Fax #: _____ Office Phone: _____

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1. DIAGNOSIS FOR DRUG REQUESTED:

- [] Chronic Kidney Disease
[] Other (specify) _____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

[] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug Name, Date, Duration. Includes blank rows for data entry.

3. PATIENT HISTORY:

- a. Is the patient currently on dialysis? [] Yes [] No
b. Has the patient tried and failed or has a contraindication/intolerance/allergy to calcium acetate? [] Yes [] No
c. Does the patient have hypercalcemia? (corrected serum calcium >10.2mg/dL) [] Yes [] No
d. Plasma Parathyroid Level (PTH) specify _____ pg/ml OR _____ pmol/L
e. Does the patient have severe vascular and/or other soft tissue calcification? [] Yes [] No

Please add any other supporting medical information that may be useful in the decision-making process:

Blank lines for additional medical information.

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only
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