Independence Blue Cross

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: ____________________

ONLY COMPLETED REQUESTS WILL BE REVIEWED

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."

Drug Name	Date	Duration

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:

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FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com

YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield. Independent licensees of the Blue Cross and Blue Shield Association.