



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Natpara

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields: Patient Name, Prescriber Name, Member Number, Fax: Phone, Date of Birth, Office Contact, Line of Business, NPI, State Lic ID, Address, City, State ZIP, Primary Phone, Specialty/facility name (if applicable)

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields: Drug Name, Strength, Directions / SIG

Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.

Q1. Is the medication being used for an FDA approved indication?

Yes No

Q2. Is the patient 18 years or older?

Yes No

Q3. Is this medication being prescribed by or in consultation with an endocrinologist or parathyroid specialist?

Yes No

Q4. Does the patient have a documented risk of osteosarcoma (including Paget's disease or unexplained elevation of alkaline phosphatase, open epiphyses, hereditary disorders predisposed to osteosarcoma, or a history of external beam or implant radiation therapy)?

Yes No

Q5. Is there documentation showing uncontrolled hypocalcemia despite treatment with calcium supplements and active forms of vitamin D?



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Form fields for Patient Name and Prescriber Name

Yes checkbox

No checkbox

Q6. Are labs attached showing serum calcium is above 7.5 mg/dL and serum 25-hydroxyvitamin D level is within normal range prior to starting Natapara?

Yes checkbox

No checkbox

Q7. Additional Information:

Prescriber Signature

Date

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