



**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:

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

Internal use only	Coverage effective date / /
Document # _____	Processor Initials _____ Date _____
M F Rx coverage Y N	STANDARD - SELECT LOB _____
Previous Auth Y N	Approved Reviewer Initials _____ Date _____