

## Fosrenol (lanthanum carbonate) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

				U	JRGENT
MEMBER INFORMATION					
LAST NAME:			FIRST NAME:		
PHONE NUMBER:			DATE OF BIRTH:	:	
STREET ADDRESS:					
CITY:			STATE:	ZIP CODE:	
PATIENT INSURANCE ID N	IUMBER:		l		
MALE FEMALE H	EIGHT (IN/CM):	WEIGH	НТ (LB/KG):	ALLERGIES:	
IF YOU ARE NOT THE PATIENT OR THE PRE FOLLOWING LINK: <u>HTTPS://MAGELLANRX</u>				RM WITH THIS REQUEST WHICH CAN BE FOUND AT THE OSURE AUTHORIZATION.PDF	į
PATIENT'S AUTHORIZED RI AUTHORIZED REPRESENTA	<del>-</del>	-			
PRESCRIBER INFORMATION	ON				
LAST NAME:		FIRST NAME:			
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:			
NPI NUMBER:		DEA NUMBER:			
PHONE NUMBER:		FAX NUMBER:			
STREET ADDRESS:					
CITY:			STATE: ZIP CODE:		
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:			
MEDICATION OR MEDICA	AL DISPENSING INFOR	RMATION			
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:		LENGTH OF THERAPY/REFILL	QUANTITY: LS:	
NEW THERAPY DURATION OF THERAPY (S	RENEW SPECIFIC DATES):	/AL	IF RENEWAL: DA	ATE THERAPY INITIATED:	
Continued on next page.					

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MEMBER'S LAST NAME:	ER'S LAST NAME: MEMBER'S FIRST NAME:		
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO	
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:	
2. LIST DIAGNOSES:		ICD-10:	
<ul> <li>□ Post-gastric bypass surgery</li> <li>□ Stage 3 to 6 chronic kidney disease (CKD</li> <li>□ Other Diagnosis</li> </ul>	·		
PRIOR AUTHORIZATION.			
Has the patient had a trial and inadeq  Yes No  Does the patient have one of the follo Calcium and phosphorus product Corrected serum calcium level gr is not being treat Parathyroid hormone (PTH) less twith corrected calcium levels of 8.4 mg/ Serum phosphorus levels greater Please provide documentation	t greater than 55mg2/dL2 eater than or equal to 9.5 mg/dL (or mathan 150 pg/ml (or less than 2 times the /dL or greater r than 6.0 mg/dL (or maximum per lab factors) oses, symptoms, medications tried or factors	eximum per lab facility) and the patient eupper limit of normal) in a patient acility)	
information is received.  ATTESTATION: I attest the information	re covered on all plans. This request may	est of my knowledge. I understand that	
information necessary to verify the acc	p or its designees may perform a routine curacy of the information reported on th	is form.	
Prescriber Signature or Electronic I.D.		Date:	
you are not the intended recipient, you are her	companying this transmission contain confidential reby notified that any disclosure, copying, distribu I have received this information in error, please neese documents.	tion, or action taken in reliance on the contents	

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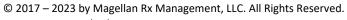


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## **FAX THIS FORM TO: 800-424-7640**

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811

St. Paul, MN 55164-0811



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