Iowa Department of Human Services

Request for Prior Authorization

Calcifediol (Rayaldee)

Provider Help Desk
1 (844) 236-1464

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for calcifediol (Rayaldee). Initial requests will be considered for patients when the following criteria are met:

1) Patient is 18 years of age or older; and
2) Patient is being treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease (CKD) as documented by a current glomular filtration rate (GFR); and
3) Patient is not on dialysis; and
4) Patient has a serum total 25-hydroxyvitamin D level less than 30 ng/mL and a serum corrected total calcium below 9.8 mg/dL within the past 3 months; and
5) Patient has documentation of a previous trial and therapy failure at a therapeutic dose with a preferred vitamin D analog for a minimum of 3 months.
6) Initial requests will be considered for a dose of 30 mcg once daily for 3 months.

Continuation of therapy will be considered when the following criteria are met:

1) Patient continues to need to be treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease (CKD) documented by a current glomular filtration rate (GFR); and
2) Patient has a serum total 25-hydroxyvitamin D level between 30 and 100 ng/mL, a serum corrected total calcium below 9.8 mg/dL, and a serum phosphorus below 5.5 mg/dL.

Requests for patients with a diagnosis of stage 5 chronic kidney disease or end-stage renal disease on dialysis will not be considered.

The required trials may be overridden when documented evidence is provided that the use of the agent(s) would be medically contraindicated.

Non-Preferred

☐ Rayaldee

Strength	Dosage Instructions	Quantity	Day's Supply
_____	_____	_____	_____

Diagnosis (provide current GFR results): ☐ Stage 3 CKD ☐ Stage 4 CKD

☐ Other_____

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Initial Requests:

Document trial of a preferred vitamin D analog:
Drug name & dose:_____ Trial dates:_____
Reason for failure:_____

Is patient on dialysis? ☐ Yes ☐ No
Serum total 25-hydroxyvitamin D level (attach results):_____ Date obtained:_____
Serum corrected total calcium level (attach results):_____ Date obtained:_____

Renewal Requests:

Does patient continue to need treatment for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease?

☐ Yes (provide current GFR results) ☐ No

Serum total 25-hydroxyvitamin D level (attach results):_____ Date obtained:_____
Serum corrected total calcium level (attach results):_____ Date obtained:_____
Serum phosphorus level (attach results):_____ Date obtained:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*