



Patient Information		Prescriber Information	
Member Name:		Prescriber Name:	
Bravo ID #		Prescriber Specialty:	
DOB:		Prescriber Address:	
Address:			
		Office Phone#:	
Home Phone:		Office Fax #:	
		Contact Person:	

**Diagnosis and Medication Requested**

Medication Requested (dosage, frequency):	Qty:
Prescribing Diagnosis:	ICD9 Code      Date Therapy Initiated:

**Clinical Criteria**

**Please answer one of the following questions:**

- Does the patient have a diagnosis of secondary hyperparathyroidism with chronic kidney disease on dialysis with a parathyroid hormone level (iPTH) of  $\geq 300$  pg/mL)?
  - Yes\*\* (Labs documenting iPTH level and dated less than 30 days must be included)
  - No
- Does the patient have a diagnosis of hypercalcemia with parathyroid carcinoma?
  - Yes\*\* (Labs documenting Calcium level and dated less than 30 days must be included)
  - No

**\*Request will be denied if above diagnosis criteria is not met.**

**\*\*Failure to provide adequate data could result in denial of this request. Lab data must be dated less than 30 days.**

Additional Comments/Explanation:

**Request for Expedited Review**

<input type="checkbox"/> <p><b>REQUEST FOR EXPEDITED REVIEW [24 HOURS]</b>  <b>BY CHECKING THIS BOX AND SIGNING BELOW, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION</b></p>
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**Prescriber's Signature:**

**Date:**