Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Parsabiv
(etelcalcetide)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Parsabiv 2.5mg/0.5ml vial ☐ Parsabiv 5mg/1ml vial ☐ Parsabiv 10mg/2ml vial

ICD10: Dose:
Frequency of therapy: Duration of therapy:
Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Parsabiv, please choose new start of therapy. ☐ new start ☐ continued therapy

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is your patient's diagnosis?
☐ Primary Hyperparathyroidism
☐ Secondary Hyperparathyroidism
☐ other *(please specify):*

Clinical Information

Does your patient have chronic kidney disease? Yes ☐ No ☐

Is your patient receiving hemodialysis? Yes ☐ No ☐

Prior to initiation, dose increase, or re-initiation of Parsabiv, is/was the corrected serum calcium level at or above the lower limit of normal as defined by the laboratory reference? Yes ☐ No ☐

According to the prescriber, does your patient have inadequate efficacy or significant intolerance to cinacalcet tablets? Yes ☐ No ☐

Is the requested medication being prescribed by or in consultation with a nephrologist or endocrinologist? Yes ☐ No ☐

Will your patient be treated with Sensipar (cinacalcet) while receiving Parsabiv? Yes ☐ No ☐

Does your patient have parathyroid carcinoma? Yes ☐ No ☐

Additional pertinent information *(including prior therapy, disease stage, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v050125