Prior Authorization Request Form for Potassium Removing Agents

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION ***(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)***

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: ______________________________

Requests for non-preferred Potassium Removing Agents: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Potassium Removing Agent? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	Medications Tried:________________ ______________________________ ______________________________ ______________________________

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.pahealthwellness.com/providers/pharmacy.html under PHW Quantity Limit List), please provide supporting information:______________________________

☐ If not prescribed by one of the following specialist cardiologist or nephrologist, please indicate a specialist consulted:______________________________

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

INITIAL REQUEST:

- ☐ Recent serum potassium levels:______________________________
- ☐ Documented therapeutic failure of **all** of the following:
  - ☐ A low potassium diet:______________________________
  - ☐ A loop or thiazide diuretic, if clinically appropriate (medication, start date and end date):______________________________
  - ☐ Discontinuation or dose reduction to the minimum effective dose of medications known to cause hyperkalemia:______________________________

RENEWAL REQUEST:

- ☐ Documentation of recent serum potassium levels demonstrating a positive clinical response to therapy:______________________________

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)