Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Healthcare Programs Prior Authorization Request Form for Use of Natpara (parathyroid hormone)

Member Name:	Date:
Member ID:	DOB:
Prescriber Name:	Specialty:
Prescriber Phone:	Prescriber Fax:

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

- Member is >18 years of age: ☐ Yes ☐ No
- Member has a diagnosis of persistent hypoparathyroidism with hypocalcemia ☐ Yes ☐ No
  - *Note: Natpara is not covered for acute post-surgical hypoparathyroidism, osteoporosis, hypocalcemia due to calcium-sensing receptor mutations, or bone healing.*
- Medication is prescribed by or in consultation with: ☐ Endocrinologist ☐ Nephrologist
- Prior therapy with BOTH of the following medications was ineffective, or not tolerated/contraindicated:
  - **Calcium**: Dates/Result:_____
  - **Calcitriol:** Dates/Result: _____
- Natpara will be used in conjunction with calcium and calcitriol supplementation ☐ Yes ☐ No
- Current total serum calcium level (albumin corrected): _____ mg/dL (*must be > 7.5 mg/dL prior to Natpara initiation*)
  - ***Action required: Attach lab report***

Limitations: Initial authorization will be issued for 6 months
Maximum 28 doses per 28 days

☐ CONTINUATION OF THERAPY

- Provide medical records (chart notes, laboratory values) documenting total serum calcium level within the lower half of the normal range (approximately 8-9 mg/dL-albumin corrected).
- Member continues to take concomitant calcium supplementation alone or with calcitriol ☐ Yes ☐ No
  - If no, provide rationale:_____
- Medication is prescribed by or in consultation with: ☐ Endocrinologist ☐ Nephrologist

Reauthorization will be issued for 12 months.

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit
1-800-294-1350