Montana Healthcare Programs Prior Authorization Request Form for Use of Natpara (parathyroid hormone)

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Member ID:</td>
<td>DOB:</td>
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<tr>
<td>Prescriber Name:</td>
<td>Specialty:</td>
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<tr>
<td>Prescriber Phone:</td>
<td>Prescriber Fax:</td>
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</tbody>
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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