health information designs

Hyperkalemia
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for select agents for hhyperkalemia to meet the following criteria:

- Patient must be 18 years of age or older
- Medication must be prescribed by, or in consultation with, a nephrologist
- Patient's current serum potassium level must be exceeding the upper limit of normal (shown by 2 labs)
- Patient must not have gastrointestinal motility disorders
- One of the following criteria must be met:
  - Patient must have failed a 30-day trial with at least one preferred product
  - Provider has submitted medical justification explaining why the patient cannot use any preferred agents
- The patient must not be receiving the medications known to cause hyperkalemia, OR medical justification must be provided explaining why discontinuation of these agents would be clinically inappropriate in this patient
- **Renewal**: Patient's current serum potassium level must be within normal limits or significantly reduced from baseline

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	

Additional Qualifications for Coverage

Has the provider attached required lab documentation showing 2 of the patient's current potassium levels?	□ YES □NO
Does the patient have a diagnosis of any gastrointestinal motility disorder?	□ YES □NO
Is the patient to continue to receive a medication known to cause hyperkalemia?	□ YES □NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #