Sensipar®
(cinacalcet) Tablets

AMGEN Assist™

1-800-272-9376 (telephone)
1-888-508-8090 (fax)

# Insurance Verification Request Form for Sensipar®

☐ **Pursue Prior Authorization if Needed**

*(Please fill out Prior Treatment History below)*

## PHYSICIAN/FACILITY INFORMATION

Contact/Requestor Name ____________________ Phone ( ____ ) ________ - ________

Facility Name ____________________ Fax ( ____ ) ________ - ________

Treating Physician's Name ____________________ State License Number ____________________

Address ____________________ Tax ID Number ____________________

City, State, ZIP Code ____________________ Physician Specialty ____________________

NPI Number ____________________ Contact/Requestor Email Address ____________________

## REQUESTOR PREFERENCES

Primary Contact for Relaying Results: ☐ Provider Contact/Requestor ☐ Physician ☐ Patient

How would you prefer results relayed? ☐ Phone ☐ Fax ☐ Email ☐ No preference

Please check all settings of care you would like researched: ☐ Retail Pharmacy ☐ Specialty Pharmacy *(approx 48 hour turnaround)* ☐ Mail Order Pharmacy *(approx 48 hour turnaround)*

☐ Dialysis Center *(approx 24 hour turnaround)*

## PATIENT GENERAL INFORMATION

First and Last Name ____________________ Date of Birth ______ / ______ / ______ (MM/DD/YYYY)

Phone ( ____ ) ________ - ________ Email Address ____________________

Address ____________________ City, State, ZIP Code ____________________

Social Security Number ______ - ______ - ______

## PATIENT MEDICAL AND TREATMENT INFORMATION

**Relevant Diagnosis (ICD-9 code):**

☐ 585.6 ☐ 585.9 ☐ 588.81 ☐ Other (Specify ICD-9 code) ____________

Dosage: ☐ 30mg ☐ 60mg ☐ 90mg ☐ Other (Specify Dosage) ____________

## PRIMARY PAYOR *(Please fax a copy of the front AND back of the insurance card(s) OR provide the information below.)*

Payor Name ____________________ Payor State ____________________

Is this a Medicare Part D Plan? ☐ Yes ☐ No If yes, provide name of Medicare Part D Plan ____________________

Payor Phone Number ( ____ ) ________ - ________ Subscriber's Name ____________________

Payor-Assigned Physician Number ____________________ Policy Number ____________________

BIN Number ____________________ PCN Number ____________________

Subscriber's Employer ____________________ Plan Name ____________________

Subscriber's Relationship to Patient ____________________ Group Number ____________________

## SECONDARY PAYOR *(Complete only if different from primary insurance information.)*

Payor Name ____________________ Payor State ____________________

Is this a Medicare Part D Plan? ☐ Yes ☐ No If yes, provide name of Medicare Part D Plan ____________________

Payor Phone Number ( ____ ) ________ - ________ Subscriber's Name ____________________

Payor-Assigned Physician Number ____________________ Policy Number ____________________

BIN Number ____________________ PCN Number ____________________

Subscriber's Employer ____________________ Plan Name ____________________

Subscriber's Relationship to Patient ____________________ Group Number ____________________

## *PRIOR TREATMENT HISTORY *(Only complete if prior authorization assistance is requested.)*

Is this patient currently receiving this drug? ☐ Yes ☐ No

Is this patient receiving dialysis treatment for treatment of chronic kidney disease? ☐ Yes ☐ No

Does this patient have a parathyroid hormone level (iPTH) of at least 300 pg/mL? ☐ Yes ☐ No

Is this drug continuing to provide clinical benefit for this patient (e.g., decrease in or maintenance of parathyroid hormone level and/or serum calcium level, serum phosphorus level, calcium-phosphorus product)? ☐ Yes ☐ No

**Patient's previous or current medical treatment for secondary hyperparathyroidism includes:**

☐ Calcium supplement (most recent date and name) ____________________ ☐ Vitamin D sterol (most recent date and name) ____________________

☐ Phosphate binder (most recent date and name) ____________________

**Statement of Medical Necessity:** *Primary Diagnosis and Date, Intact PTH Level, Serum Calcium, and Serum Phosphorus*

Additional Lab Values or other supporting information to establish medical necessity: ____________________

I certify that Sensipar® therapy is necessary for this patient. I will be supervising the patient's treatment accordingly.

Physician's Signature ____________________ Date ____________________

*This verification of benefits is not a guarantee of payment by the payor, but is deemed as current coverage information as relayed by the payor to the Amgen Assist Hotline.* *(c)2009 Amgen. All rights reserved.* *NOTE TO PATIENT/PROVIDER: Please ensure that the patient consent form is completed and returned to Covance along with this Insurance Verification Form.*