Sensipar®

(cinacalcet HCl)

Insurance Verification Request Form

Amgen Reimbursement Connection®
1-800-272-9376 (telephone)
1-888-508-8090 (fax)

Insurance Verification Only? ☐
Need only complete Physician, Patient, and Insurance Information sections.

Please complete this form and fax it to 1-888-508-8090 for processing only.

PHYSICIAN/FACILITY INFORMATION

Contact/Requestor Name ____________________ Phone (________) _________ - ____________________
Facility Name ____________________ Fax (________) _________ - ____________________
Treating Physician's Name ____________________ *Tax ID # ____________________
Address ____________________ State License # ____________________
City, State, Zip____________________ Physician Specialty ____________________
DEA # ____________________

*Required if patient has a form of commercial insurance.

REQUESTOR PREFERENCES

Primary Contact for Relaying Results: ☐ Provider Contact ☐ Patient   How would you prefer results relayed? Phone Fax No preference
Please check all settings of care you would like researched: Retail Pharmacy Mail Order Specialty Pharmacy Other________________________

PATIENT GENERAL INFORMATION

Patient Name ____________________ Patient DOB ______ / ______ / ______ (mm/dd/yy)
Patient Phone (________) _________ - ____________________ Social Security # _________ - _________ - ___________
Patient Address ____________________ Patient State & Zip Code ____________________

PATIENT MEDICAL INFORMATION

Relevant Diagnosis
☐ End stage renal disease (585.6) ☐ Chronic kidney disease, unspecified (585.9) ☐ Secondary hyperparathyroidism, renal (588.81)
☐ Other (specify ICD-9 code) _______

INSURANCE INFORMATION *Please check all that apply.* (Complete for Medicaid and BCBS only)

☐ Patient has Medicaid. If patient has Medicaid, please include the physician's Medicaid provider#: ____________________
☐ Patient has BCBS. If patient has BCBS, please include the physician's BCBS provider#: ____________________

PRIMARY INSURANCE (Please fax copy of front AND back of insurance card(s) OR provide the information below.)

Insurance Name ____________________ Insurance State ____________________
Insurance Phone Number (______) ________ - ________________ Provider # for this Policy ____________________
Policyholder's Name ____________________ Policy Number ____________________
Policyholder's SSN _________ - _________ - __________________ Group/Plan Number ____________________

SECONDARY INSURANCE *Complete only if different from primary insurance information.*

Insurance Name ____________________ Insurance State ____________________
Insurance Phone Number (______) ________ - ________________ Provider # for this Policy ____________________
Policyholder's Name ____________________ Policy Number ____________________
Policyholder's SSN _________ - _________ - __________________ Group/Plan 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 parathyroid hormone level and/or calcium phosphorous product)? ☐ Yes ☐ No
Patient's previous or current medical treatment for secondary hyperparathyroidism includes:
☐ calcium supplement (date)_____________ ☐ Vitamin D sterol (date)______________ ☐ phosphate binder (date)________________
Statement of Medical Necessity: Primary Diagnosis and Date, Intact PTH Level, Serum Calcium, and 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 payer, but is deemed as current coverage information as relayed by the payer to the Amgen Reimbursement Connection®. This verification cannot take the place of written policy information from the payer.