OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Miacalcin® Injection Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Hypercalcemia
- ❑ Paget's disease
- ❑ Postmenopausal osteoporosis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

For hypercalcemia, answer the following:

Select if the patient has severe hypercalcemia as confirmed by the following:

- ❑ Corrected total serum calcium ≥ 12 mg/dL
- ❑ Corrected total serum calcium ≥ 6mEq/L

For Paget's disease, answer the following:

Does the patient have history of failure, contraindication, or intolerance to one oral bisphosphonate [e.g., Fosamax (alendronate)]? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient continue to have symptoms (e.g., bone pain and/or deformity, neurologic disorders, elevated cardiac output, and other vascular disorders, high output heart failure)? ❑ **Yes** ❑ **No**

Are the serum alkaline phosphatase and/or urinary hydroxyproline levels elevated based on the normal reference ranges provided by the physician's laboratory? ❑ **Yes** ❑ **No**

For postmenopausal osteoporosis, answer the following:

Does the patient have history of failure, contraindication, or intolerance to one standard therapy [e.g., Fosamax (alendronate), Evista (raloxifene)]? ❑ **Yes** ❑ **No**

Does the patient have history of failure or intolerance to Miacalcin nasal spray (calcitonin-salmon)? ❑ **Yes** ❑ **No**

Select if the patient has history of the following fractures resulting from minimal trauma:

- ❑ Vertebral compression fracture
- ❑ Fracture of the hip
- ❑ Fracture of the distal radius

Does the patient have a bone mineral density (BMD) scan indicative of osteoporosis [t-score of less than or equal to -2.5 (2.5 standard deviations or greater below the mean for young adults)]? ❑ **Yes** ❑ **No**

Miacalcin® Injection Prior Authorization Request Form (Page 2 of 2)

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Quantity Limit Requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
  - ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.