

SENSIPAR

TELEPHONE 1-800-237-2767 FAX 1-800-323-2445

1. PATIENT INFORMATION *To be completed by the patient*

| | | | | |
|------------------------------|--------------------------------|---|--|------|
| Last Name | | First Name | | M.I. |
| Street Address | | City | | |
| State | | ZIP | | |
| Day Telephone # (+Area Code) | Night Telephone # (+Area Code) | Mobile Telephone # (+Area Code) | | |
| Date of Birth (MM/DD/YYYY) | Social Security # | Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F | | |
| Parent/Guardian Name | | | | |

INSURANCE INFORMATION

| | | | |
|---|--|---|--|
| Primary/Medical Insurance | | Secondary/Pharmacy Insurance | |
| Cardholder Name & ID # (If Not Patient) | | Cardholder Name & ID # (If Not Patient) | |
| Group/Policy # | | Group/Policy # | |
| Insurance Telephone # (+Area Code) | | Insurance Telephone # (+Area Code) | |
| Employer | | Medicaid # | |

ALTERNATE SHIPPING ADDRESS

| | | | | |
|----------------|--|------------|--|-------|
| Last Name | | First Name | | M.I. |
| Street Address | | City | | State |
| State | | ZIP | | |

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

2. PHYSICIAN INFORMATION *To be completed by the physician and staff*

| | | | |
|--------------------------|--------------------|-------------------------|-----|
| Prescriber's Last Name | | Prescriber's First Name | |
| Hospital/Clinic | | Office Contact | |
| Street Address | | | |
| City | | State | ZIP |
| Telephone # (+Area Code) | Fax # (+Area Code) | E-Mail Address | |
| Prescriber's License # | DEA # | NPI # | |
| UPIN# | | Medicaid License # | |

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: (ICD-9 CM Code Plus Description)

- 588.81 Secondary Hyperparathyroidism (of renal origin)
 275.42 Hypercalcemia 194.1 Parathyroid Carcinoma
 Other ____ Date of Diagnosis ____ / ____ / ____

Intact PTH Level ____ pg/mL Date Level Drawn ____ / ____ / ____
 Serum Calcium ____ mg/dL Date Level Drawn ____ / ____ / ____
 Serum Phosphorus ____ mg/dL Date Level Drawn ____ / ____ / ____

Does Patient Have a History of Seizure Disorder? Yes No

Patient's Previous or Current Medical Treatment for Secondary Hyperparathyroidism Includes:

- Calcium Supplement Date ____ / ____ / ____ Vitamin D Analog Date ____ / ____ / ____
 Phosphate Binder Date ____ / ____ / ____ Other ____ Date ____ / ____ / ____

Rx

Patient Weight ____ kg. OR ____ lbs.

Drug Allergies ____

NKDA

Sensipar™ 30 mg Tablet 60 mg Tablet 90 mg Tablet
 Quantity ____ SIG: ____

Other ____

Other Prescriber's Notes:

| | |
|--|--|
| | |
|--|--|

- Refill ____ Times
 Dispense As Written Substitution Allowed

| | |
|------------------------|------|
| Prescriber's Signature | Date |
| | |

PHYSICIAN SPECIALTY: Nephrologist Other (Specify) ____

3. FAX COMPLETED FORM TOLL-FREE TO CAREMARKCONNECT® @ 1-800-323-2445

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.

Thank you for choosing Caremark!