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Auryxia® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			**Provider Information (required)**		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP:	Office Street Address:		
Phone:			City:	State:	ZIP:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	

Clinical Information (required)	
1. Does the patient have one of the following diagnosis? *(If yes, check which applies)* □ Iron deficiency anemia in chronic kidney disease not on dialysis □ Hyperphosphatemia in chronic kidney disease on dialysis	❑ Yes ❑ No
2. Has the patient demonstrated a failure of or intolerance to at least 2 of the following? *(If yes, check which applies)* □ Calcium acetate □ Lanthanum carbonate □ Sevelamer carbonate	❑ Yes ❑ No
Reauthorization:	
1. Is there documentation of serum calcium, phosphorus, and parathyroid hormone levels? *If yes, please submit documentation (e.g., chart notes, laboratory values) along with this fax or document the patient's serum calcium, phosphorus, and parathyroid hormone levels below:* _____ _____ _____	❑ Yes ❑ No

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

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 more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern.