FAX Completed Form To
1.877.386.4695

Provider Help Desk
1.866.399.0928

Request for Prior Authorization
POTASSIUM BINDERS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for potassium binders subject to clinical criteria. Payment will be considered under the following conditions:

1) **Patient is 18 years of age or older; and**
2) **Patient has a diagnosis of chronic hyperkalemia; and**
3) **Patient has documentation of a recent trial and therapy failure with sodium polystyrene sulfonate.**

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

☐ Lokelma ☐ Veltassa

Strength_____ **Dosage Instructions**_____ **Quantity**_____ **Days Supply**_____

Diagnosis:_____

Sodium polystyrene sulfonate trial: Dose:_____ Trial dates:_____

Failure reason:_____

Medical or contraindication reason to override trial requirements:_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*