



Physician's Prior Authorization Questionnaire for Zemplar®

PATIENT'S NAME: _____ ID#: _____ DOB: _____

Patient Address: _____

Zemplar® is covered under certain clinical conditions. Please furnish the information below to assist us in making a determination of this patient's eligibility for coverage for treatment with this drug.

1. What is the patient's diagnosis (**Please do not use codes**)? _____

What Stage? _____

2. What is the patient's iPTH level? _____

3. What is the patient's calcium level? _____

4. In what strength and how often is this medication being prescribed? _____

The patient will not be able to get more than one (1) month supply at a time.

Physician's Signature

Date

Please **Print** Name

Fax Number

Please **Print** Physician's Specialty

Phone Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact ABCBS at (501) 378-3392. For your convenience, you may fax your response(s) back to ABCBS at (501) 378-6980.

Sincerely,
Pharmacy Programs

Forms are also available online at <http://usableadmin.abcbs.net/providers/PharmacyForms.aspx>