Texas Medicaid/CHIP Vendor Drug Program
Texas Standard Prior Authorization Form Addendum
Phosphate Binders (required for non-preferred agents only)

In addition to the ***Texas Standard Prior Authorization Request Form for Prescription Drug Benefits***, please complete the information below. This information is essential to processing the prior authorization for the selected drug. Incomplete forms or failure to submit this addendum may cause delays in patient care and/or prior authorization denial. Please fax the completed Standard Prior Authorization Form and Addendum to (866) 469-8590 for Fee-For-Service patients. If the patient is enrolled in managed care, please contact the appropriate health plan for forms and instructions.

SECTION I — PATIENT INFORMATION

NAME:	MEDICAID ID #:	DOB:

SECTION II — PRESCRIBER INFORMATION

NAME:	NPI#:	PHONE:

SECTION III — MEDICATION INFORMATION

1. Does the patient have a diagnosis of end-stage renal disease (ESRD)?	☐ Yes	☐ No
2. Does the patient have a diagnosis of hyperphosphatemia despite phosphorous restrictions?	☐ Yes	☐ No
3. Does the patient have hypercalcemia (corrected serum calcium > 10.2 mg/dl)?	☐ Yes	☐ No
4. Have plasma parathyroid hormone (PTH) levels been < 150 pg/ml on two consecutive measurements?	☐ Yes	☐ No
5. Is the patient on dialysis with severe vascular and/or soft tissue calcifications?	☐ Yes	☐ No

SECTION IV — REVIEW

☐ Expedited/Urgent Review Requested

By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

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Signature of Prescriber or Prescriber's Designee Date