Arkansas Department of Health
**Arkansas Kidney Disease Commission**
4815 W. Markham St. Slot 35 | Tel: 501-686-2807 | Fax: 501-686-2831

# Request for Prior-Approval of Sensipar Co-Payment

**Date:** _____ **(NOTE: ALL INFORMATION MUST BE COMPLETED AND LEGIBLE)**

| Client/Patient Information: | | | | | |
|---|---|---|---|---|---|
| *First Name* | *Last Name* | | | | *Middle Initial* |
| *Physical Street Address* | *City* | | *State* **AR** | *Zip Code* | *County* |
| *Phone Number* | *Social Security Number* | *Other medical conditions* | | | |

| Dialysis/Social Worker Information: | | | | |
|---|---|---|---|---|
| *Name of Social Worker* | *Social Worker Email Address* | | | |
| *Phone Number* | *Facsimile Number* | *Dialysis Center/Facility* | | |
| *Street Address* | *City* | *State* **AR** | *Zip Code* | |

Patient has: Medicare ☐ Medicaid ☐ Private Insurance with Rx Coverage ☐ None ☐

Relevant Diagnoses:

_____

Treatment Previously Used to Address Diagnoses:

_____

Client is aware the AKDC will not provide payment for the full cost of Sensipar and that the program will only participate in the purchase of the drug as a co-payer.

_____ _____
*Signature of Social Worker or Dietitian* *Date*

_____ _____
*Signature of Prescribing Physician* *Date*

| AKDC Use Only | Referral approval date: _____ Renewal approval date: _____ |
|---|---|
| | ☐ Approved ☐ Denied *Signature* _____ *Date* _____ |

*Revised: May 2018*