MEDICATION POLICY

Generic Name: Cinacalcet

Therapeutic Class or Brand Name: Sensipar®

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 2/5/16 **Date Last Reviewed/Revised:** 5/1/18

GPI Code: 3090522510

Prior Authorization Criteria (may be considered medically necessary when criteria I through III are met):

I. Documented diagnosis of one of the following conditions A through C AND must meet criteria listed under applicable diagnosis:
   A. Secondary Hyperparathyroidism (HPT) due to chronic kidney disease AND all of criteria 1 through 3 are met:
      1. Documentation that the patient is on dialysis.
      2. Documentation that patient has a current intact PTH (iPTH) level of at least 300 pg/mL.
      3. Documented trial and failure of or contraindication to one phosphate binder (i.e. calcium acetate, Fosrenol®, Renvela®, Renagel®, etc.) AND one vitamin D analog (i.e. calcitriol, doxercalciferol, paricalcitol, etc.)
   B. Hypercalcemia due to Parathyroid Carcinoma (PC).
   C. Hypercalcemia due to primary HPT AND both of criteria 1 and 2 are met:
      1. Documentation that patient is unable to undergo parathryoidectomy.
      2. Documentation that patient has a current serum calcium of greater than 12.5 mg/dL.

II. Minimum age requirement: 18 years old.

III. Prescriber must be a nephrologist, endocrinologist, or oncologist.

Exclusion Criteria:

- Serum calcium is less than the lower limit of the lower range.

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

Disclaimer: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgment in providing the most appropriate care for their patients.

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- Up to a maximum of 120 tablets per 30 days.

Approval Length:

- **Authorization:** 12 months.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

Appendix:

N/A

References:

1. http://pi.amgen.com/united_states/sensipar/sensipar_pi_hcp_english.pdf.
2. Medi-Span.
3. http://www.bcbsnc.com/assets/services/public/pdfs/formulary/Sensipar_Criteria.pdf.
4. https://www.azblue.com/~/media/azblue/files/pharmacy-forms-mastery-directory/group/prior-authorization-guidelines/sensipar.pdf.

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Historical Tracking Of Changes Made To Policy	
5/1/2018	1. Policy reviewed: no changes made.
7/14/2017	1. Policy reviewed: no changes made.

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