



DEPARTMENT OF WORKFORCE EDUCATION
 ARKANSAS REHABILITATION SERVICES
 ARKANSAS KIDNEY DISEASE COMMISSION
 26 CORPORATE HILL DRIVE
 LITTLE ROCK, ARKANSAS 72205
 PHONE (501) 686-2807 ♦ FAX (501) 686-2831



REQUEST FOR PRIOR-APPROVAL OF SENSIPAR CO-PAYMENT

(NOTE: ALL INFORMATION MUST BE COMPLETED AND LEGIBLE)

_____ *Date*

Patient's Name: _____ SSN: _____
 Contact Information: _____ Tel: () _____

Relevant Diagnoses:

Treatment Previously Used to Address Diagnoses:

Dialysis Center: _____ Tel: () _____
 Contact Information: _____ Fax: () _____

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	Approved <input type="checkbox"/>	Denied <input type="checkbox"/>
_____ <i>Signature</i>		_____ <i>Date</i>

Revised 2/12/08