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# 2019 Procrit® (epoetin alfa) Prior Authorization Request

**Page 1 of 2**
**(You must complete both pages.)**

**Fax completed form to: 1-800-408-2386** **For urgent requests, please call: 1-800-414-2386**

| **Patient information** | | **Prescriber information** | |
|---|---|---|---|
| Patient name | | Today's date | Physician specialty |
| Patient insurance ID number | | Physician name | NPI/DEA number |
| Patient address, city, state, ZIP | | Physician address, city, state, ZIP | |
| Patient home telephone number | | M.D. office telephone number | |
| Gender ☐ Male ☐ Female | Patient date of birth | M.D. office fax number | |

**Diagnosis and medical information**

| Medication requested | Diagnosis |
|---|---|
| ☐ Procrit | ☐ Anemia due to chronic kidney disease (CKD)<br>☐ Anemia due to end stage renal disease (ESRD) with DIALYSIS<br>☐ Anemia due to myelosuppressive anticancer chemotherapy<br>☐ Anemia due to zidovudine therapy in an HIV-infected patient<br>☐ Surgical procedure -Transfusion of blood product, allogeneic; prophylaxis<br>☐ Anemia due to myelodysplastic syndromes (MDS)<br>☐ Anemia in congestive heart failure (CHF)<br>☐ Anemia in rheumatoid arthritis (RA)<br>☐ Anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa)<br>☐ Anemia in primary myelofibrosis<br>☐ Post-polycythemia vera myelofibrosis<br>☐ Post-essential thrombocythemia myelofibrosis<br>☐ Anemia in patients whose religious beliefs forbid blood transfusions<br>☐ Other diagnosis/(ICD10): _____ |

| Strength and route of administration | Quantity | Day supply | Expected length of therapy |
|---|---|---|---|
| | | | |

**Please check all boxes that apply:**

☐ New start ☐ Restart ☐ Renewal

1. **Where is medication being administered?**
   ☐ Patient's home (self-administered) ☐ Office administered (office supplies drug) / J CODE: _____
   ☐ Office administered (pharmacy supplies drug) ☐ Dialysis center

2. ☐ **All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.**

3. ☐ Yes ☐ No **Is the patient on dialysis? ? If yes, please answer the following:**
   ☐ Yes ☐ No Does the prescriber (i.e. nephrologist, nurse practitioner, or physician assistant) receive a monthly capitation payment to manage ESRD patients' care?
   ☐ Yes ☐ No Is the Procrit to be used for an ESRD-related condition?

4. **For all uses EXCEPT surgical procedures, please answer the following:**
   ☐ Yes ☐ No Was the patient's hemoglobin (Hgb) level prior to treatment with erythropoietin less than 10 g/dL for all diagnoses or less than 9 g/dL for anemia in CHF only (**Please note**: pre-treatment value is the Hgb level when the patient had received no erythropoietin in the previous month)

*continued on next page*

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**Please check all boxes that apply *(continued)*:**

5. ☐ Yes ☐ No **Is Procrit requested for the treatment of anemia due to primary myelofibrosis (MF), post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis? If YES, please answer the questions below:**
   - ☐ Yes ☐ No Does the patient have symptomatic anemia?
   - ☐ Yes ☐ No For initial therapy, was the pretreatment serum erythropoietin level less than 500 mU/mL.

6. ☐ Yes ☐ No **Is Procrit requested for a patient undergoing an elective, noncardiac, nonvascular surgery? If YES, please answer the following question:**
   - ☐ Yes ☐ No Is the pretreatment (perioperative) Hgb greater than 10 g/dL but not more than 13 g/dL?

7. ☐ Yes ☐ No **Is this a request for a reauthorization (patient received erythropoietin in previous month)? If YES, please answer the following questions:**
   - ☐ Yes ☐ No Has the patient received a recent blood transfusion?
   - ☐ Yes ☐ No If patient has NOT received a recent blood transfusion, has there been an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy?

8. ☐ Yes ☐ No **If patient has anemia due to myelosuppressive cancer chemotherapy, does the patient have a current Hgb less than 11 g/dL? (or less than 12 g/dL for patient with anemia NOT due to myelosuppressive cancer chemotherapy)**

9. **For new starts and renewals**:

**Please complete this section below only if your patient does not meet the standard requirements listed above.**
Please explain why your patient should be considered for exception although not meeting the plan's suggested PA criteria. Statement should include specifically which requirement is not met and why patient should be exempt from meeting this requirement. (Please note any information that is incomplete or illegible will delay the review process.)

10. ☐ Yes ☐ No **Procrit is not covered for patients receiving chemotherapy with curative intent or patients with myeloid cancer. Is the patient receiving chemotherapy with curative intent or does the patient have a diagnosis of myeloid cancer?**

11. ☐ **Other supporting information:**

*NOTE: Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

| **Prescriber signature** | **Date** |
|---|---|
| | |