

2018 Procrit® (epoetin alfa) Prior Authorization Request

Page 1 of 2

(You must complete both pages.)

Fax completed form to: 1-800-639-9158

For urgent requests, please call: 1-800-551-2694

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient date of birth	M.D. office fax number	
Diagnosis and medical information			
Medication requested <input type="checkbox"/> Procrit	Diagnosis <input type="checkbox"/> Anemia due to chronic kidney disease (CKD) <input type="checkbox"/> Anemia due to end stage renal disease (ESRD) with DIALYSIS <input type="checkbox"/> Anemia due to myelosuppressive anticancer chemotherapy <input type="checkbox"/> Anemia due to zidovudine therapy in an HIV-infected patient <input type="checkbox"/> Surgical procedure -Transfusion of blood product, allogeneic; prophylaxis <input type="checkbox"/> Anemia due to myelodysplastic syndromes (MDS) <input type="checkbox"/> Anemia in congestive heart failure (CHF) <input type="checkbox"/> Anemia in rheumatoid arthritis (RA) <input type="checkbox"/> Anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa) <input type="checkbox"/> Anemia in primary myelofibrosis <input type="checkbox"/> Post-polycythemia vera myelofibrosis <input type="checkbox"/> Post-essential thrombocythemia myelofibrosis <input type="checkbox"/> Other diagnosis/(ICD10): _____		
Strength and route of administration	Quantity	Day supply	Expected length of therapy
Please check all boxes that apply:			
<input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Renewal			
1. Where is medication being administered? <input type="checkbox"/> Patient's home (self-administered) <input type="checkbox"/> Office administered (office supplies drug) / J CODE: _____ <input type="checkbox"/> Office administered (pharmacy supplies drug) <input type="checkbox"/> Dialysis center			
2. <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient on dialysis? ? If yes, please answer the following: <input type="checkbox"/> Yes <input type="checkbox"/> No Does the prescriber (i.e. nephrologist, nurse practitioner, or physician assistant) receive a monthly capitation payment to manage ESRD patients' care? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the Procrit to be used for an ESRD-related condition?			
4. For all uses EXCEPT surgical procedures, please answer the following: <input type="checkbox"/> Yes <input type="checkbox"/> 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

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. **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.)

8. ☐ 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?**

9. ☐ **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