

Aranesp, Epogen, Procrit Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. Which drug is being prescribed? Aranesp Epogen Procrit Other _____
2. What is the prescribed dosage?

<input type="checkbox"/> 0.45 mcg/Kg weekly	<input type="checkbox"/> 300 Units/Kg per day
<input type="checkbox"/> 2.25 mcg/Kg weekly	<input type="checkbox"/> 500 mcg once every 3 weeks
<input type="checkbox"/> 50-100 units/Kg 3 times weekly	<input type="checkbox"/> 600 Units/Kg once weekly for 4 weeks
<input type="checkbox"/> 100 units/Kg 3 times weekly	<input type="checkbox"/> 40,000 Units weekly
<input type="checkbox"/> 150 Units/Kg 3 times weekly	<input type="checkbox"/> Other _____
3. What is the diagnosis? Anemia associated with concomitantly administered chemotherapy
 Anemia associated with chronic renal failure Human immunodeficiency virus (HIV) infection
 Elective, non-cardiac, non-vascular surgery Other _____
4. What is the medical specialty of the prescribing physician?
 Hematologist Nephrologist Oncologist Specialist in HIV treatment Other _____
5. What is the ferritin level? _____ ng/mL Transferrin saturation? _____ % **(fax results)**
6. Document patient's **BASELINE** Hemoglobin (Hgb) concentration prior to starting Aranesp/ Epogen/ Procrit therapy. _____ g/dL Date _____ **(Fax copy of results)**
7. Document the prescriber's target (e.g., therapeutically optimal) Hgb level/range. _____ g/dL
8. Will Hgb be monitored weekly until stabilized? Yes No
9. Will CBC w/ differential and platelet count be monitored regularly, every 3 to 6 months?
 Yes No
10. Will blood pressure be monitored weekly and antihypertensive therapy be initiated or dosage adjusted accordingly? Yes No
11. Is the patient currently receiving Aranesp/Epogen/Procrit therapy (within the last 30 days)?
 Yes, **Date of last injection** _____ **If yes, complete Section E AND diagnosis section*
 No **If no, complete the diagnosis section only*

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

Section A: Anemia associated with concomitantly administered chemotherapy

12. Does the patient have a diagnosis of non-myeloid malignancy? Yes No
13. **Attach chemotherapy treatment regimen.**
14. Is the patient currently or will be enrolled in a risk evaluation and mitigation strategy (REMS) program?
 Yes No

Section B: Anemia associated with chronic renal failure

15. Is the patient's blood pressure adequately controlled? Yes No
16. Is the prescribed medication for the immediate correction of severe anemia (eg, as a substitute for an **emergency** transfusion)? Yes No

Section C: Human Immunodeficiency virus (HIV) infection

17. Does the patient have anemia due to following factors: Yes No
 Iron or folate deficiencies Hemolysis Gastrointestinal (GI) or other bleeding
18. Is the patient currently receiving HIV treatment with Zidovudine? Yes No
19. Is the patient currently receiving Zidovudine dose less than or equal to 4200 mg per week?
 Yes No
20. What is the endogenous serum erythropoietin level? _____ mU/mL **(please fax results)**

Section D: Surgery patients

21. Is the patient at high risk for perioperative transfusions with significant, anticipated blood loss?
 Yes No
22. Will the patient donate autologous blood? Yes No
23. Will Epogen/Procrit be given for 10 days before surgery, on the day of surgery and for 4 days after surgery? Yes No
24. Will Epogen/Procrit be given 21, 14, and 7 days before surgery plus a fourth dose on the day of the surgery? Yes No

Section E: Recertification

25. For how many weeks has patient been on therapy? _____ **weeks**
26. Document patient's **CURRENT** Hemoglobin (Hgb) level. _____ g/dL
27. **Attach documentation of monitored Hgb level over the current treatment period.**
28. If current Hgb is greater than 12 g/dL, will the dose be held until Hgb level falls below 11 g/dL?
 Yes No
29. Did current Hgb rise greater than or equal to 1 g/dL compared to pre-treatment level? Yes No
30. Has Hgb increased greater than or equal to 1g/dL in any 2 week period? Yes No

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31. Is Hgb increasing and approaching 12 g/dL? Yes No
32. Has the patient reached dose 300 units/Kg 3 times a week? Yes No
33. Will the dose:
- Continue the same as starting dose
 - Be decreased by 25%
 - Be increased by 25%

****NOTE: We can NOT make a decision without a copy of the documentation - Thank You****

Information given on this form is accurate as of this date:

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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