CarePlus HEALTH PLANS

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Epoetin alfa (Epogen, Procrit) 29

Phone: 1-866-315-7587 Fax to: 1-800-310-9071

CarePlus manages the pharmacy drug benefit for your patient. Certain requests for prior authorization require additional information from the prescriber. Please provide the following information and fax this form to the number listed above. Information left blank or illegible may delay the review process.

Patient name:	**Prescriber name:**	
Member/subscriber number:	Fax:	Phone:
Patient date of birth:	Office contact:	
Group number:	NPI:	Tax ID:
Address:	Address:	
City, state ZIP:	City, state ZIP:	
	Specialty/facility name (if applicable):	

Drug name:	☐ Expedited/exigent/urgent
Directions/SIG:	By checking this box, I certify an expedited/exigent/urgent review is required. The member has a health condition that may seriously jeopardize his/her life or ability to regain maximum function. **(Please include explanation of exigency in the space below.)**
Quantity:	

Is this a proactive request for a new plan year? Yes____ No____ If yes, please provide plan year:_____

(Please note: All reviews will be processed with generic equivalents for brand drugs whenever possible.)

Please attach pertinent medical history or information for this patient that may support approval and sign this form.

Q1. Please provide if the patient has anemia associated with the diagnosis of: *

- ☐ Chronic Kidney Disease (CKD)
- ☐ Cancer: anemia while on chemotherapy for non-myeloid, non-erythroid malignancy
- ☐ Zidovudine (AZT) therapy in HIV infected patients
- ☐ Patients scheduled to undergo elective, non-cardiac, non-vascular surgery
- ☐ Myelodysplastic Syndrome (MDS)
- ☐ Management of Hepatitis C
- ☐ Rheumatoid Arthritis
- ☐ Other

Q2. If other, please specify:

Q3. Please provide J-Code, if applicable:

Q4. Please provide ICD Diagnostic Codes:

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Q5. Please indicate which one of the following applies:

☐ The drug is billed, dispensed and administered by: physician, physician-based infusion clinic, or hospital-based infusion clinic on patient's behalf

☐ The drug is billed and shipped from a retail pharmacy on patient's behalf to the physician's office or facility (non-self-administered infusible drug)

☐ The drug is dispensed to the patient by a retail pharmacy

☐ Home Health Service (supplied and administered)

☐ Long Term Care (supplied and administered)

☐ Skilled Nursing Facility (supplied and administered)

Q6. If Skilled Nursing Facility, is the patient's stay covered by Part A?

☐ Yes ☐ No

Q7. **For facilities other than the prescriber's office, please provide where the drug will be obtained and administered:

Q8. Please check the place of treatment billing code:

☐ 11 – Office

☐ 12 – Home

☐ 19 – Outpatient Hospital (Off-Campus)

☐ 22 – Outpatient Hospital (On-Campus)

☐ Pharmacy dispensed

☐ Infusion suites

☐ Other (i.e. ER, Inpatient, Skilled Nursing)

Q9. If other, please specify:

Q10. Is the patient on dialysis?

☐ Yes ☐ No

Q11. Is the drug requested part of a clinical trial?

☐ Yes ☐ No

Q12. If yes, please provide the registration or identification number for the specific trial for which this drug is being studied: (e.g. ClinicalTrials.gov Identifier: NCT12345678):_____

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Q13. Is the request for a reauthorization (the patient is currently on therapy)?

☐ Yes ☐ No

Q14. Has there been a dose reduction of epoetin for maintenance therapy?

☐ Yes ☐ No

Q15. Will the requested drug be used in combination with another Erythropoietin Stimulating Agent?

☐ Yes ☐ No

Q16. Is the patient currently receiving iron therapy if indicated?

☐ Yes ☐ No

Q17. Please provide the most recent Hemoglobin (Hgb) level within the last 4 weeks:

☐ Less than 10.0
☐ Equal to 10.0
☐ 10.1-10.9
☐ 11.0 to 11.9
☐ Equal to 12.0
☐ 12.1 to 13.0
☐ 13.1 or greater

Q18. Please indicate the highest Hemoglobin (Hgb) increase from baseline (prior to epoetin alfa therapy):

☐ 0.9 g/dL or less ☐ 1.0-1.4 g/dL ☐ 1.5-1.9 g/dL ☐ 2.0 g/dL or greater

Q19. Is the hematocrit (HCT) level less than 30%?

☐ Yes ☐ No

Q20. If the hematocrit (HCT) is greater than or equal to 30%, please provide level:

Q21. Is the Transferrin Saturation/Iron Saturation/Tsats greater than or equal to 20%?

☐ Yes ☐ No

Q22. If the Transferrin Saturation/Iron Saturation/Tsats are less than 20%, please provide level:

Q23. Document the date of Transferrin Saturation/Iron Saturation/Tsats testing:

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Q24. Is the Serum Ferritin level greater than or equal to 100 ng/ml?

☐ Yes ☐ No

Q25. If the Serum Ferritin is less than 100 ng/ml, please provide level:

Q26. Document the date of Serum Ferritin testing:

Q27. Is the Serum Erythropoetin level less than or equal to 500 mUnits/ml?

☐ Yes ☐ No

Q28. Have other causes of anemia including iron, B-12, folate deficiencies, hemolysis, and bleeding been ruled out?

☐ Yes ☐ No

Q29. If the patient is currently on chemotherapy, is the intent of chemotherapy curative?

☐ Yes ☐ No

Q30. If the patient is currently taking Zidovudine (AZT), is the total dose less than or equal to 4200 mg per week?

☐ Yes ☐ No

Q31. If the diagnosis is MDS, has there been a decrease in RBC transfusion requirements?

☐ Yes ☐ No

Q32. If the diagnosis is Hepatitis C, is the patient receiving Ribavirin with either Interferon or PEG-Interferon?

☐ Yes ☐ No

Q33. Is the patient currently on therapy for treatment of Rheumatoid Arthritis known to cause anemia?

☐ Yes ☐ No

Q34. Please provide previous therapies used with start/end dates and reason for discontinuing drug(s) that would be pertinent to the review of the drug requested:

Prescriber signature

Date

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