

Ticket #: _____ Request Date: _____ Request Time: _____

Epogen® Prior Authorization Request Form (Page 1 of 3)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Anemia due to chronic kidney disease</p> <p><input type="checkbox"/> Anemia in cancer patients on chemotherapy</p> <p><input type="checkbox"/> Anemia in hepatitis C virus (HCV)-infected patients due to ribavirin in combination with interferon or peg-interferon</p> <p><input type="checkbox"/> Anemia in HIV-infected patients</p> <p><input type="checkbox"/> Anemia in patients with myelodysplastic syndrome (MDS)</p> <p><input type="checkbox"/> Preoperative use for reduction of allogeneic blood transfusion in patients undergoing surgery</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>

<p>Medication History:</p> <p>Is this request for continuation of Epogen therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have history of failure, contraindication, or intolerance to Aranesp? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have history of failure, contraindication, or intolerance to Procrit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>For anemia due to chronic kidney disease, answer the following:</p> <p>Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient been evaluated for adequate iron stores? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within 30 days of this request: Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____</p> <p>Does the rate of hemoglobin decline indicate the likelihood of requiring a red blood cell (RBC) transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the goal of therapy to reduce the risk of alloimmunization and/or other RBC transfusion-related risks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Reauthorization:</p> <p>Has the patient been evaluated for adequate iron stores? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there a decrease in the need for blood transfusion with Epogen therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Document the hemoglobin (Hgb) and hematocrit (Hct) levels collected from the past 3 months:</p> <p>Hgb: _____ Hct: _____ Date: _____</p> <p>Hgb: _____ Hct: _____ Date: _____</p> <p>Hgb: _____ Hct: _____ Date: _____</p>

Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.

Office use only: Epogen_Comm_2017Dec

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For anemia in cancer patients on chemotherapy, answer the following:

Have all other causes of anemia been ruled out? Yes No

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within **the prior two weeks** of this request:

Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____

Has the patient been evaluated for adequate iron stores? Yes No

Is the cancer a non-myeloid malignancy? Yes No

Is the patient concurrently on chemotherapy? Yes No

Will the patient be receiving concomitant chemotherapy for a minimum of 2 months? Yes No

Is the anemia caused by cancer chemotherapy? Yes No

Reauthorization:

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within **the prior two weeks** of this request:

Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____

Is there a decrease in the need for blood transfusion with Epogen therapy? Yes No

Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? Yes No

Is the patient concurrently on chemotherapy? Yes No

Will the patient be receiving concomitant chemotherapy for a minimum of 2 months? Yes No

Is the anemia caused by cancer chemotherapy? Yes No

For anemia in HCV-infected patients due to ribavirin in combination with interferon or peg-interferon, answer the following:

Does the patient have a diagnosis of hepatitis C virus (HCV) infection? Yes No

Has the patient been evaluated for adequate iron stores? Yes No

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within **30 days** of this request:

Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____

Is the patient receiving ribavirin? Yes No

Is the patient receiving interferon alfa-2b, interferon alfacon-1, peginterferon alfa-2b, or peginterferon alfa-2a? Yes No

Reauthorization:

Is there a decrease in the need for blood transfusion with Epogen therapy? Yes No

Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? Yes No

Document the hemoglobin (Hgb) and hematocrit (Hct) levels collected from the past 3 months:

Hgb: _____ Hct: _____ Date: _____

Hgb: _____ Hct: _____ Date: _____

Hgb: _____ Hct: _____ Date: _____

For anemia in HIV-infected patients, answer the following:

Has the patient been evaluated for adequate iron stores? Yes No

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within **30 days** of this request:

Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____

Is the serum erythropoietin level less than or equal to 500 mU/mL? Yes No

Is the patient receiving zidovudine (AZT) therapy? Yes No

Does the patient have a diagnosis of HIV infection? Yes No

Reauthorization:

Is there a decrease in the need for blood transfusion with Epogen therapy? Yes No

Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? Yes No

Document the hemoglobin (Hgb) and hematocrit (Hct) levels collected from the past 3 months:

Hgb: _____ Hct: _____ Date: _____

Hgb: _____ Hct: _____ Date: _____

Hgb: _____ Hct: _____ Date: _____

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For preoperative use for reduction of allogeneic blood transfusion in patients undergoing surgery, answer the following:

- Is the patient scheduled to undergo elective, non-cardiac, non-vascular surgery? Yes No
Is the hemoglobin (Hgb) > 10 to ≤ 13 g/dL? Yes No
Is the patient at high risk for perioperative transfusions? Yes No
Is the patient willing or able to donate autologous blood pre-operatively? Yes No
Has the patient been evaluated for adequate iron stores? Yes No

For anemia in patients with myelodysplastic syndrome (MDS), answer the following:

- Is the serum erythropoietin level less than or equal to 500 mU/mL? Yes No
Does the patient have transfusion-dependent MDS? Yes No
Has the patient been evaluated for adequate iron stores? Yes No

Reauthorization:

- Is there a decrease in the need for blood transfusion with Epogen therapy? Yes No
Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? Yes No
Document the hemoglobin (Hgb) and hematocrit (Hct) levels collected from the past 3 months:

Hgb: _____ Hct: _____ Date: _____
Hgb: _____ Hct: _____ Date: _____
Hgb: _____ Hct: _____ Date: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Authorized Medical Signature: _____

Telephone: _____

Date: _____

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.