ERYTHROPOIESIS STIMULATING PROTEINS PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774.**

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New ☐ Renewal	# pages in this request:	Additional information (PA#:____________________)
Office Contact Name:	Phone:	

PATIENT INFORMATION

Name:	Patient ID #:	Date of birth:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	
NPI#: **OR** MA Provider ID #		State license #:
Prescriber address:	Suite #:	City/state/zip:
Phone:	Fax:	
Long-term care facility (if applicable) contact name:	Phone:	

MEDICAL INFORMATION

1. **Drug Requested:** ☐ Aranesp (Preferred) ☐ Epogen (Preferred) ☐ Mircera (Preferred) ☐ Procrit (Non-preferred) ☐ Retacrit (Preferred)
   Epogen/Procrit/Retacrit strength: __________ units/mL Aranesp/Mircera strength: _____ mcg/_____ mL Choose: ☐ Syringe or ☐ Vial
2. Dose:_________ Directions:____________________________________ Quantity:_________ Refills:___________
3. Diagnosis – Anemia due to ______________________________ Diagnosis Code: ____________ *(required)*
4. Is this a new start for the patient? ☐ Yes ☐ No – Document date treatment was initiated: ____________________

5. PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication)**:**

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #: Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

Epogen Requests:

1. Has the patient tried and failed any of the Preferred agents (Procrit and Aranesp)? ☐ Yes *(Submit documentation)* ☐ No
2. Does the patient have a contraindication or intolerance to either Preferred agent? ☐ Yes *(Submit documentation)* ☐ No

<u>All Requests:</u> Please complete the following clinical information:

1. Blood Pressure: ________________________________ Date taken:_______
2. Current Weight: _____________ pounds or _____________ kilograms Date taken:_______
3. Transferrin or Iron Saturation: ____________________________% Date taken:_______
4. Ferritin Level: _________________________________ ng/mL Date taken:_______
5. Vitamin B12 (cobalamin) Level: ____________________________ Date taken:_______
6. Folate (folic acid) Level: _________________________________ Date taken:_______
7. Pre-Treatment Hemoglobin Level: _________________________g/dL Date taken:_______
8. Current (if applicable) Hemoglobin Level: ____________________ g/dL Date taken:_______

<u>For Anemia Due to Chronic Kidney Disease:</u>

9. Glomerular Filtration Rate: ______ mL/min or Serum Creatinine : _____mg/dL Date taken: ________
10. If ≤ 18 years – document physician specialty: ☐ Hematology ☐ Nephrology ☐ Other: ______________________________

<u>For Anemia Due to Chemotherapy:</u>

11. Chemotherapy Agents:____
12. Date of most recent treatment: _________________________ Anticipated duration of treatment: ________________

<u>For Anemia Due to Zidovudine for Treatment of HIV:</u>

13. Weekly zidovudine dose: ______________ mg/ week
14. Erythropoietin Level: ________________________________ mUnits/mL Date taken: ________________

<u>For Anemia Due to Ribavirin for Treatment of Hepatitis C:</u>

15. Is the patient having symptoms due to the decrease in Hemoglobin? ☐ Yes (Submit documentation) ☐ No
16. What week of Hepatitis C treatment is the patient in currently? Week: _______________

<u>For the Reduction of Allogeneic Blood Transfusion in Surgery:</u>

17. Is the patient undergoing elective, non-cardiac, non-vascular surgery? ☐ Yes ☐ No
18. If yes, document type of surgery: ______________________________ and Anticipated Surgery Date: _______________

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:

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