

ERYTHROPOIETINS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis (ICD code plus description):	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? Yes No
2. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
If yes, please specify FDA labeled contraindication: _____
3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., nephrologist, oncologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
4. Prior to starting the requested agent, were the patient's iron stores evaluated, and blood ferritin found to be at least 100 ng/mL (nanograms per milliliter) OR transferrin saturation found to be at least 20%? Yes No
5. Will iron stores be maintained before starting and while using ESA therapy?..... Yes No
6. Is the patient's blood pressure adequately controlled and closely monitored before and during ESA therapy? Yes No
7. Is the ESA dose the lowest dose that will gradually increase Hgb concentration to the lowest level sufficient to avoid the need for red blood cell (RBC) transfusion? Yes No
8. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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Please indicate for which of the following conditions this patient requires treatment with an erythropoietin stimulating agent and answer the corresponding questions:

Anemia associated with chronic kidney disease (including end stage renal disease-ESRD)

9. Does the patient have an Hgb level of less than 11 g/dL (or less than 10 g/dL for patients initiating ESA therapy) and the requested agent will be used to reduce the need for red cell transfusions? Yes No

Anemia associated with hepatitis C

10. Is the patient being treated with the combination of ribavirin and interferon alfa OR ribavirin and peginterferon? Yes No

11. Have other causes of anemia been ruled out? Yes No

12. Has the patient failed to respond (i.e., severe anemia) within two weeks after reducing the dose of Ribavirin by 200 mg/day from the initial dose (NOTE: Use of erythropoietin may be considered prior to dose reduction for the following: 1) documented evidence of cirrhosis, or 2) post liver transplant, or 3) HIV co-infection)? Yes No

13. Is the patient's Hgb less than 10 g/dL, or is the patient symptomatic and has Hgb less than 11 g/dL? Yes No

Anemia in a patient with myelodysplastic syndromes

14. Is the requested agent being used to reduce transfusion dependency? Yes No

Anemia in cancer patients with metastatic non-myeloid malignancies

15. Is the patient undergoing myelosuppressive chemotherapy? Yes No

16. Is the patient's anemia caused by myelosuppressive chemotherapy? Yes No

17. Is the patient's anemia due to other factors (e.g., iron or folate deficiencies, hemolysis, gastrointestinal bleeding, or underlying hemolytic disease [e.g., sickle cell anemia, thalassemia, porphyria])? Yes No

18. Is the anticipated outcome of myelosuppressive therapy a cure? Yes No

19. Does the patient have an Hgb level of 12 g/dL or less (or approaching or has fallen below 10 g/dL for patients initiating ESA therapy)? Yes No

Anemia related to therapy with AZT (zidovudine) in HIV-infected (human immunodeficiency virus) patients

20. Is the patient's endogenous serum erythropoietin level less than or equal to 500 mUnits/mL? Yes No

To reduce the need for allogeneic blood transfusion in a pre-operative surgery patient

21. Is the patient scheduled for elective, non-cardiac, non-vascular surgery? Yes No

22. Is the patient at high risk for significant perioperative blood loss? Yes No

23. Is the patient a candidate for autologous blood transfusion? Yes No

24. Is the patient's hemoglobin level less than 13 g/dL? Yes No

Other (ICD code plus description): _____

25. Does the patient have an FDA labeled indication for the requested agent and route of administration? Yes No

If yes, is the patient's hemoglobin level within FDA labeling for patients initiating ESA therapy or for patients stabilized on therapy for the requested indication? Yes No

If no, does the patient have an indication that is supported in compendia (AHFS, or DrugDex 1, 2a, or 2b level of evidence, NCCN 1, 2a, or 2b recommended use) for the requested agent and route of administration? Yes No

If yes, is the patient's hemoglobin level within compendia (AHFS, or DrugDex 1, 2a, or 2b level of evidence, NCCN 1, 2a, or 2b recommended use) recommended range for the requested indication for patients initiating ESA therapy or for patients stabilized on therapy for the requested indication? Yes No

Please fax or mail this form to:
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TOLL FREE

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