

# Pharmacy Prior Authorization Form

Last Reviewed: Sept. 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

**Epogen<sup>®</sup>, Procrit (epoetin alfa)**  Urgent  Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Epogen

Procrit

Strength:

2,000 units/mL  3,000 units/mL  4,000 units/mL  10,000 units/mL  20,000 units/mL

40,000 units/mL

Dose: \_\_\_\_\_ Start date: \_\_\_\_\_

## Priority Health Precertification Requirements:

### Authorization for Epogen/Procrit requires:

- Diagnosis of anemia associated with chemotherapy for non-myeloid malignancies, chronic renal failure, secondary to Zidovudine treatment, and preoperative use
- Hemoglobin and hematocrit levels
  - Chemotherapy and Zidovudine treatment: hemoglobin level of < 10 g/dL or hematocrit level < 30%
  - Chronic renal failure: hemoglobin level 8-13 g/dL or hematocrit level > 24 to ≤ 39%
- Transferrin saturation at least 20% and serum ferritin at least 100 ng/ml
- Erythropoietin level of at least 500 million units/ml (for anemia secondary to Zidovudine therapy only)
- Preoperative use:
  - Patient is undergoing elective noncardiac, nonvascular surgery
  - Patient is not a candidate for autologous blood transfusion
  - Patient is expected to lose at least 2 units of blood
  - Patient will be receiving adequate iron supplementation during treatment
- Patient cannot have any of the following conditions/contraindications
  - Prophylaxis use to reduce tumor hypoxia
  - Uncontrolled hypertension
  - Erythyroid Cancer
  - Radiotherapy alone
  - Hematocrit level ≤ 24%
  - Chronic Myelogenous Leukemia
  - Acute Myelogenous Leukemia

- Anemia due to folate deficiency, iron deficiency, B12 deficiency, hemolysis, bleeding or bone marrow fibrosis
- Anemia of cancer not related to cancer treatment
- Prophylactic use to prevent chemotherapy-induced anemia
- Erythropoietin-type resistance due to neutralizing antibodies

**Continuation of Epogen/Procrit requires:**

- Chemotherapy: hemoglobin level remains < 10 g/dL or hematocrit level remains < 30%
  - Maintenance of ESA therapy is recommended at the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is  $\geq 1$ g/dL or the rise in hematocrit  $\geq 3\%$
  - For patients whose hemoglobin rises <1 g/dl (hematocrit rise <3%) compared to pretreatment baseline over 4 weeks of treatment and whose hemoglobin level remains <10 g/dL after the 4 weeks of treatment or the hematocrit is <30%, the recommended FDA label starting dose may be increased once by 25%
  - Continued administration of the drug is not reasonable and necessary if there is a rapid rise in hemoglobin > 1 g/dl (hematocrit > 3%) over 2 weeks of treatment unless the hemoglobin remains below or subsequently falls to < 10 g/dL (or the hematocrit is < 30%). Continuation and reinstitution of ESA therapy must include a dose reduction of 25% from the previously administered dose
  - Continued use of the drug is not reasonable and necessary if the hemoglobin rises <1 g/dl (hematocrit rise <3 %) compared to pretreatment baseline by 8 weeks of treatment
- Chronic renal failure: hemoglobin level remains 8-13 g/dL or hematocrit level remains > 24 to  $\leq 39\%$

Diagnosis:

- Non-Myeloid Malignancy
- Chronic Renal Failure/ESRD
- Anemia Secondary to Zidovudine treatment
- Preoperative Use (please complete section below **and** the preoperative use section)
- Other: \_\_\_\_\_ Please provide rationale for use:

Hemoglobin (Hgb)

Baseline level: \_\_\_\_\_ Date of lab: \_\_\_\_\_  
 Current level: \_\_\_\_\_ Date of lab: \_\_\_\_\_

Hematocrit (Hct)

Baseline level: \_\_\_\_\_ Date of lab: \_\_\_\_\_  
 Current level: \_\_\_\_\_ Date of lab: \_\_\_\_\_

Transferrin saturation: \_\_\_\_\_ Date of lab: \_\_\_\_\_

Serum ferritin: \_\_\_\_\_ Date of lab: \_\_\_\_\_

Serum erythropoietin level: \_\_\_\_\_ Date of lab: \_\_\_\_\_

Patient's weight: \_\_\_\_\_

Patient is currently on dialysis:

- Yes
- No

Patient has the following conditions or contraindications (please check all that apply):

- Prophylaxis use to reduce tumor hypoxia
- Uncontrolled hypertension
- Erythyroid Cancer
- Radiotherapy alone
- Hematocrit level  $\leq$  24%
- Chronic Myelogenous Leukemia
- Acute Myelogenous Leukemia
- Anemia due to folate deficiency, iron deficiency, B12 deficiency, hemolysis, bleeding or bone marrow fibrosis
- Amemia of cancer not related to cancer treatment
- Prophylactic use to prevent chemotherapy-induced amenia
- Erythropeietin-type resistance due to neutralizing antibodies

If you have indicated that the patient has any of the above, please provide the rationale for use:

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New request or continuation of therapy:

- New
- Continuation (please complete the continuation section)

**Please complete this section only if request is for Preoperative Use:**

Patient is undergoing elective, noncardiac, nonvascular surgery:

- Yes
- No - Rationale for use: \_\_\_\_\_

Patient is a candidate for an autologous blood transfusion:

- Yes – Rationale for use: \_\_\_\_\_
- No

Patient is expected to lose  $\geq$  2 units of blood:

- Yes
- No – Rationale for use: \_\_\_\_\_

Patient will be receiving adequate iron supplementation during therapy:

- Yes
- No – Rationale for use: \_\_\_\_\_

**Continuation Section (please complete this section if this request is for continuation of therapy:**

Patient has been on Aranesp therapy for \_\_\_\_\_ weeks

Rise in Hgb over the baseline level: \_\_\_\_\_

Rise in Hct over the baseline level: \_\_\_\_\_

Continuation dose:

- Requested dose is the same as previous dose
- Requested dose is 25% higher than the previous dose
- Requested dose is 25% lower than the previous dose
- Other: Please provide the change in dose and rationale: \_\_\_\_\_  
\_\_\_\_\_

**\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\***  
**Please fax this request to: (877)974-4411 toll free or (616)942-8206**  
**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**