PriorityHealth®

Pharmacy
Prior Authorization Form

Last Reviewed: Sept. 07

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®, Procrit® (epoetin alfa)

***This medication must be dispensed at a participating Specialty Pharmacy.**

Member Name: ________________________________ Member #: ______________-___

DOB: _____________________________ Sex: ______ Provider Phone: _____________

Provider Name: ________________________________ Provider Fax: ________________

Provider Office Contact Name: ____________________ Date: ______________________

Please choose the appropriate medication and strength:

☐ Epogen ☐ Procrit

☐ 2,000 units/ml ☐ 3,000 units/ml ☐ 4,000 units/ml ☐ 10,000 units/ml ☐ 20,000 units/ml ☐ 40,000 units/ml

Priority Health precertification requirements: (Check which applies)

☐ 1. Anemia due to chronic renal failure
☐ 2. Anemia due to cancer chemotherapy. **All** of the following must apply: (Check those that apply)

- ☐ Anemia is symptomatic:
- ☐ Hemoglobin has dropped more than 1 g/dl since initiation of chemotherapy;
- ☐ Hemoglobin is less than 11 g/dl
- ☐ Chemotherapy is expected to continue for more than one month;

☐ 3. Anemia due to zidovudine (AZT) therapy for AIDS

Laboratory Requirements (please fill in blanks):

	Current		**Previous**	
Hemoglobin (g/dL)	__________	Date: __________	__________	Date: __________
Hematocrit (%)	__________	Date: __________	__________	Date: __________
Serum Ferritin (mcg/L)	__________	Date: __________	__________	Date: __________
Serum Transferrin Saturation (%)	__________	Date: __________	__________	Date: __________
Creatinine Clearance (ml/min)	__________	Date: __________	__________	Date: __________

Note:

1. *Authorization requires Hemoglobin <10g/dL in chronic renal failure and <11g/dL in HIV or cancer AND Hematocrit <30% in chronic renal failure and <33% in HIV or cancer*
2. *Serum ferritin levels should be maintained > 100mg/mL and serum transferrin saturation should be maintained > 20%*

Therapy Duration:

- The dose of Epogen/Procrit should be adjusted for each patient to achieve and maintain a target hemoglobin level not to exceed 12g/dL.

Dosing Recommendations:

- Chronic renal failure: initiate at no more than 50u/kg three times weekly or 10,000 units once weekly. Maximum dose is 18,000 units per week.
- Chemotherapy: initiate at no more than 150 units/kg three times weekly. Maximum dose is 300 units/kg three times per week.

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- AZT therapy for AIDS: initiate at no more than 100 units/kg three times per week.
- Patients whose hematocrit has not increased within 4 – 6 weeks at 150u/kg should be increased to 300u/kg for 4 – 6 weeks. If hematocrit still has not increased, patient should be considered nonresponders, and medication should be discontinued
- Dosing should be decreased if hematocrit increase by more than 4 points in any 2-week period
- Dosing should be adjusted after 8 weeks and at monthly intervals thereafter as necessary to maintain a hematocrit of 30-34% for Chronic Renal Failure or 36% to 40% for HIV and cancer.

For Internal Use Only

Original Date of Req: ___________________ Non-Urgent: ___ Urgent: ___ Retro: ___ Method: Phone ___ Fax ___ Ltr ___ Coord. Initial ____

Approved: ____ Denied: ____ Letter Type: Denial ___ 48 hr ___ Off-Label Use ___ Verbal: Y ___ N___ Inquiry number: __________________

Product: HMO ___ PPO ___ ASO ___ POS ___ Caid ___ MIChild ___ Mcare ___ McarePlus ___ McareRX ___ McareValue ____

Formulary (11/0030/R0) _____ Non-Formulary (11/0032/R0) ____

Dte Addt Info Req _______________ by: Phone ___ Fax ___ Dte 48/OL Ltr sent:_______________ Dte 2nd 48/OL Ltr Sent (Caid only) ____________

Date All Info Recvd __________________ Date of Decision to Deny: __________________ RPh Initials: ____________________________

Notified: _______________________ of Denial on: __________________ by: Ph ___ Fax ___ Provider Fax #:_______________________________