COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
PHONE 1-800-537-8862 FAX 1- 866-327-0191

Effective 9/28/15

ERYTHROPOIESIS STIMULATING PROTEINS

PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Erythropoiesis Stimulating Proteins, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Erythropoiesis Stimulating Proteins (accessible at: http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm)

PRIOR AUTHORIZATION REQUEST INFORMATION

□ New □ Renewal □ Additional Information (PA#:_____)

pages in this request:_____ Office Contact Name:_____ Phone:(_____)_____

RECIPIENT INFORMATION

Name:_____ Recipient ID#:_____ Date of Birth: _____

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: ☐ Epogen (**Non-preferred**) ☐ Procrit (**Preferred**) ☐ Aranesp (**Preferred**)

Epogen/Procrit Strength: _____ Units/mL **Aranesp 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 recipient? ☐ Yes ☐ No – document date treatment was initiated**:** _____

5. Which Specialty Pharmacy does the recipient wish to use? ☐ Diplomat Specialty Pharmacy ☐ Walgreens Specialty Pharmacy

Epogen Requests:

1. Has the recipient tried and failed any of the Preferred agents (Procrit & Aranesp)? ☐ Yes (*Submit documentation)* ☐ No

2. Does the recipient have a contraindication or intolerance to either Preferred agent? ☐ Yes (*Submit documentation)* ☐ No

All Requests: Please complete the following clinical information and submit documentation:

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:** _____

For Anemia Due to Chronic Kidney Disease:

9. Glomerular Filtration Rate: _____ **mL/min or Serum Creatinine :** _____**mg/dL** **Date Taken:** _____

10. If ≤ 18 years – document physician specialty: ☐ **Hematology** ☐ **Nephrology** ☐ **Other:** _____

For Anemia Due to Chemotherapy:

11. Chemotherapy Agents:_____

12. Date of most recent treatment: _____ **Anticipated duration of treatment:** _____

For Anemia Due to Zidovudine for Treatment of HIV:

13. Weekly zidovudine dose: _____ **mg/ week**

14. Erythropoietin Level: _____ **mUnits/mL** **Date Taken:** _____

For Anemia Due to Ribavirin for Treatment of Hepatitis C:

15. Is the recipient having symptoms due to the decrease in Hemoglobin? ☐ Yes (*Submit documentation)* ☐ No

16. What week of Hepatitis C treatment is the recipient in currently? Week: _____

For the Reduction of Allogeneic Blood Transfusion in Surgery:

17. Is the recipient 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 CLINICAL INFORMATION TO DPW – PHARMACY DIVISION

Prescriber Signature:_____ **Date:**_____