

ERYTHROPOIESIS STIMULATING PROTEINS PRIOR AUTHORIZATION FORM

See the Pharmacy Services website at: <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx> for prior authorization guidelines.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pgs: _____		Prescriber name:	
Name of office contact:			Specialty:		
Contact's phone number:			NPI:		State license #:
LTC facility contact/phone:			Street address:		
Beneficiary name:			Suite #:	City/State/Zip:	
Beneficiary ID#:		DOB:	Phone:		Fax:
Drug requested:			Strength & vial size:		<input type="checkbox"/> single-dose vial <input type="checkbox"/> multi-dose vial
Dose/directions:				Quantity:	Duration:
Diagnosis (<i>submit documentation</i>):				Dx code (<i>required</i>):	
For non-preferred medication: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.				<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
Complete the section(s) below applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.					
<input type="checkbox"/> Has transferrin or iron saturation $\geq 20\%$ and ferritin ≥ 100 ng/mL <input type="checkbox"/> Has adequately controlled blood pressure <input type="checkbox"/> Had vitamin B12 and folate levels evaluated and is receiving therapeutic supplementation as indicated <input type="checkbox"/> For treatment of anemia associated with <u>chronic kidney disease</u> – INITIAL request: <input type="checkbox"/> Has irreversible kidney disease as defined by the National Kidney Foundation's KDOQI <input type="checkbox"/> Has hemoglobin < 10 g/dL <input type="checkbox"/> For treatment of anemia associated with <u>chronic kidney disease</u> – RENEWAL request: <input type="checkbox"/> Has an increased hemoglobin level since starting treatment with the requested medication <input type="checkbox"/> Is receiving dialysis and has a hemoglobin ≤ 11 g/dL <input type="checkbox"/> Is not receiving dialysis and has a hemoglobin ≤ 10 g/dL <input type="checkbox"/> For treatment of anemia in patients with <u>cancer receiving chemotherapy</u> – INITIAL request: <input type="checkbox"/> Is currently receiving myelosuppressive chemotherapy <input type="checkbox"/> Has hemoglobin < 10 g/dL <input type="checkbox"/> For treatment of anemia in patients with <u>cancer receiving chemotherapy</u> – RENEWAL request: <input type="checkbox"/> Has an increased hemoglobin level since starting treatment with the requested medication <input type="checkbox"/> Has a hemoglobin ≤ 12 g/dL <input type="checkbox"/> For treatment of anemia in patients with <u>HIV infection receiving zidovudine</u> – INITIAL request: <input type="checkbox"/> Has a serum erythropoietin level ≤ 500 mU/mL <input type="checkbox"/> Is taking zidovudine at a dose of ≤ 4200 mg/week <input type="checkbox"/> Has hemoglobin < 10 g/dL <input type="checkbox"/> For treatment of anemia in patients with <u>HIV infection receiving zidovudine</u> – RENEWAL request: <input type="checkbox"/> Has an increased hemoglobin level since starting treatment with the requested medication <input type="checkbox"/> Has a hemoglobin ≤ 12 g/dL <input type="checkbox"/> For reduction of allogeneic blood transfusion in <u>surgery patients</u>: <input type="checkbox"/> Has hemoglobin > 10 g/dL and ≤ 13 g/dL <input type="checkbox"/> Will be undergoing elective, non-cardiac, non-vascular surgery <input type="checkbox"/> For treatment of anemia caused by <u>ribavirin</u> in patients treated for <u>hepatitis C virus infection</u> – INITIAL request: <input type="checkbox"/> Has hemoglobin < 10 g/dL or is symptomatic and has hemoglobin < 11 g/dL <input type="checkbox"/> For treatment of anemia caused by <u>ribavirin</u> in patients treated for <u>hepatitis C virus infection</u> – RENEWAL request: <input type="checkbox"/> Has an increased hemoglobin level since starting treatment with the requested medication <input type="checkbox"/> Has a hemoglobin ≤ 12 g/dL					

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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