

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Red Blood Cell Growth Factor(s) PreDetermination of Medical Benefits

[Epogen® & Procrit® (epoetin alfa); Aranesp® (darboepoetin alfa)]

Complete form in its entirety and fax to UM Call Center at (404) 848-2448

Click on grey boxes to type

Request Date: _____ / _____ / _____

Initial Authorization Request Re-Authorization Request; List Prior Auth Ref #: _____

Yes No Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800.870.6419)

1. PATIENT INFORMATION (Note: ESRD patients for whom Medicare is primary, prior authorization is not required.)

Patient Last Name		Patient First Name		Patient ID Number		Patient DOB / /	
Address			City		State / Zip Code /		Contact Phone Number () -
Date of Diagnosis / /	Primary Diagnosis			ICD-9 Code(s)		Patient's Current Weight	
Patient's Current Hemoglobin (Hgb) Level				Date Hgb Measured / /			

2. PHYSICIAN INFORMATION

Physician Last Name		Physician First Name		Physician DEA or NPI Number		Physician Tax ID	
Address			City		State		Zip Code
Office Phone Number () -	Office Fax Number () -		Office Contact Name			Physician Specialty	

3. FACILITY* INFORMATION (IF APPLICABLE)

Facility Name			Facility DEA or NPI Number		Facility Tax ID		
Address			City		State		Zip Code
Facility Phone Number () -		Facility Fax Number () -		Facility Contact Name			

* If a (dialysis) facility is providing these medications, please provide all of the prescribing physician's info above (#2) and facility info here (#3).

4. MEDICATION INFORMATION

Drug Name <input type="checkbox"/> Procrit <input type="checkbox"/> Epogen <input type="checkbox"/> Aranesp		HCPCS or CPT Code(s) <input type="checkbox"/> Q4081 <input type="checkbox"/> J0885 <input type="checkbox"/> J0886 <input type="checkbox"/> J0881 <input type="checkbox"/> J0882		Strength / Dose (mg/kg)		
Direction for Use (SIG)						
Date patient is scheduled to be treated (need by date) / /		Service From Date / /		Service Thru Date / /		Number of Refills
Place of Service <input type="checkbox"/> MD Office <input type="checkbox"/> Pt's Home <input type="checkbox"/> Not applicable <input type="checkbox"/> Other:						
Prescriber Signature					Date / /	

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5. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: **To avoid delays**, please complete section 1 for any initial requests and then section 2 and 3 as appropriate for the drug.
If indicated, please provide **ALL** supporting lab results, progress notes, etc.

(1) Pre-qualifying Criteria (must answer before proceeding to #2)

- Yes No Is pt's hemoglobin (Hgb) level < 10 g/dL prior to initiation of therapy (unless specified below)?
Please provide current Hgb level: _____ Date: ____ / ____ / ____
- Yes No Prior to initiation of therapy, was pt's iron status evaluated?
Please provide current transferrin saturation: _____ Date: ____ / ____ / ____
And current serum ferritin level: _____ Date: ____ / ____ / ____
- Yes No Does pt have hypertension?
 Yes No If pt has hypertension, was pt's blood pressure adequately controlled before initiation of therapy?

(2) For Procrit and Epogen Use(s)

- Yes No Is pt diagnosed with anemia associated with chronic renal failure?
- Yes No If so, is the patient on renal dialysis?
- Yes No Is pt diagnosed with cancer and being treated for chemotherapy induced anemia?
- Yes No Is chemotherapy planned for at least 2 months?
- Yes No Is the patient diagnosis non-myeloid cancer with an anticipated outcome of not cure?
- Yes No Is pt being treated for anemia in myelodysplastic syndrome?
- Yes No If so, is pt's endogenous erythropoietin level < 500 mU/mL?
- Yes No Is pt HIV positive and is being treated for anemia associated with zidovudine therapy?
- Yes No Is pt's current zidovudine dose ≤ 4200 mg/week?
- Yes No Is pt being treated for preoperative anemia to reduce the need for allogeneic blood transfusions?
- Yes No Is pt's hemoglobin > 10 to ≤ 13g/dL?
- Yes No Is pt scheduled to undergo elective, non-cardiac, nonvascular surgery?
- Yes No Is pt at high risk for perioperative transfusions with significant anticipated blood loss?
- Yes No Is pt unwilling or unable to donate autologous blood?
- Yes No Has antithrombotic prophylaxis been considered?
- Yes No Is pt diagnosed with hepatitis C?
- Yes No Is pt currently on concomitant therapy of ribavirin plus interferon alpha or ribovirin plus or peginterferon alpha?
- Yes No Is pt diagnosed with chronic inflammatory disease and is being treated for chemotherapy induced anemia?
- Yes No Is pt being treated post allogeneic bone marrow transplantation?

(3) For Aranesp Use(s)

- Yes No Is pt diagnosed with anemia associated with chronic renal failure (including both pts on dialysis and not on dialysis)?
- Yes No Is pt diagnosed with cancer and being treated for chemotherapy induced anemia?
- Yes No Is chemotherapy planned for at least 2 months?
- Yes No Is the patient diagnosis non-myeloid cancer with an anticipated outcome of not cure?
- Yes No Is pt being treated for anemia in myelodysplastic syndrome?
- Yes No If so, is the pt's endogenous erythropoietin level < 500mU/ml?

(4) Other Use(s) (This will not be reviewed unless all supporting evidence/documentation, labs, etc., are attached.)

6. PHYSICIAN SIGNATURE

	/ /
Prescriber Signature	Date

Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine Anthem UM Services, Inc. an independent company and is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.
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what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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Medical Policy Reference can be found at: www.bcbsga.com