ERYTHROPOIESIS STIMULATING PROTEINS PRIOR AUTHORIZATION FORM

(form effective 1/5/21)

Keystone First Community HealthChoices | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New ☐ Renewal	# pages in this request:	Additional information (PA#:_____)
Office Contact Name:	Phone:	

PATIENT INFORMATION

Name:	Patient ID #:	Date of birth:
Street address:	Apt. #:	City/state/zip:

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:** ☐ Aranesp (non-preferred) ☐ Epogen (Preferred) ☐ Mircera (non-preferred) ☐ Procrit (non-preferred) ☐ Retacrit (Preferred)
   Epogen/Procrit/Retacrit strength: _____ units/mL Aranesp/Mircera 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 patient? ☐ Yes ☐ No – Document date treatment was initiated: _____
5. **PHARMACY INFORMATION** (Prescriber to identify the pharmacy that is to dispense the medication)**:**
   Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:
   Pharmacy Phone #: Pharmacy Fax #:
   ☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

Epogen Requests:

1. Has the patient tried and failed any of the Preferred agents (Epogen and Retacrit)? ☐ Yes *(Submit documentation)* ☐ No
2. Does the patient have a contraindication or intolerance to either Preferred agent? ☐ Yes *(Submit documentation)* ☐ No

All Requests: Please complete the following clinical information:

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 patient having symptoms due to the decrease in Hemoglobin? ☐ Yes (Submit documentation) ☐ No
16. What week of Hepatitis C treatment is the patient in currently? Week: _____

For the Reduction of Allogeneic Blood Transfusion in Surgery:

17. Is the patient 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 REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: