## **ERYTHROPOIESIS STIMULATING PROTEINS** PRIOR AUTHORIZATION FORM





(form effective 1/5/21)

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

Plane	PRIOR AUTHORIZATION REQUEST INFORMATION					
Patent IU P	☐ New ☐ Renewal # pages in this request:			Additional information (PA#:	)	
Name	Office Contact Name: Pho	ne:				
Name	PATIENT INFORMATION					
Speciality:   OR MA Provider   D			Patient ID #:		Date of birth:	
Prescriber name:   Specialty:   Specialty:   State license #:		Ant.		City/state/zin:		
Pecarcher name:   Seculary   Seculary   State liciense #   State li		7.104.1		orsy, otato, E.p.		
NPiet:   OR   MA Provider ID #   State license #:   Procest cardienses:   Sull #   City/state/zip:   City/state/zip:   Procest cardienses:   Procest ca			0			
Prescriber address:   Prome:						
Prione:   Fac:   Prione:	NPI#: OR MA Provider ID #		State license #:			
Nemoticate   Nem	Prescriber address:	Suit	e #:	City/state/zip:		
MEDICAL INFORMATION	Phone:		Fax:			
1. Drug Requested:   Aranses (one)-preferred)   Epogen (Preferred)   Epogen/Procrit (Preferred)   Epoge	Long-term care facility (if applicable) contact name:		Phone:			
1. Drug Requested:   Aranses (one)-preferred)   Epogen (Preferred)   Epogen/Procrit (Preferred)   Epoge	MEDICAL INFORMATION					
2. Dose:   Directions:   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 Briefer   Pharmacy Name:	1. Drug Reguested:  Aranesp (non-preferred)  Epogen (Preferred)  Mircera (non-preferred)  Procrit (non-preferred)  Retacrit (Preferred)					
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. PHARMACV INFORNATION (Prescriber to identify the pharmacy that is to dispense the medication):	Epogen/Procrit/Retacrit strength: units/mL Aranesp/Mircera strength: mcg/ mL Choose: □ Syringe or □ Vial					
4. Is this a new start for the patient?   ves   No Document date treatment was initiated:   5. PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):						
5. PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):    Deliver to:   Patient's None   Physician's Office   Patient's Preferred Pharmacy Name:   Pharmacy Prome #:   Pharmacy Prome #						
Deliver to:   Patient's Home   Physician's Office   Patient's Preferred Phirmacy Phone #: Pharmacy Phone Pho	4. Is this a new start for the patient? ☐ Yes ☐ No – Document date treatment was initiated:					
Pharmacy Phone #: Phone						
lacknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.   Fopogra Requests:   1. Has the patient tried and failed any of the Preferred agents (Epogen and Retacrity)   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:						
Epogen Requests:  1. Has the patient tried and failed any of the Preferred agents (Epogen and Retacrit)	, manuacy ran in					
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:   9% Date taken:   5. Ferritin Level:   ng/mL Date taken:   6. Folate (folic acid) Level:   Date taken:   6. Folate (folic acid) Level:   Date taken:   7. Fre-Treatment Hemoglobin Level:   g/dL Date taken:   8. Current (if applicable) Hemoglobin Level:   g/dL Date taken:   9. Glomerular Filtration Rate:   mL/min or Serum Creatinine:   mg/dL Date taken:   10. If 18 years - document physician specialty:   Hematology   Nephrology   Other:   11. Chemotherapy Agents:   12. Date of most recent treatment:   Anticipated duration of treatment:   13. Weekly zidovudine dose:   mg/mek  Treatment of HIV! 13. Weekly zidovudine dose:   mg/mek  Date taken:   14. Erythropietin Level:   mUhritis/mL Date taken:   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:   17. Is the patient undergoing elective, non-cardiac, non-vascular surgery?   Yes   No 18. If yes, document type of surgery:   and Anticipated Surgery Date:						
2. Does the patient have a contraindication or intolerance to either Preferred agent?   Ves (Submit documentation)   No   All Requests: Please complete the following clinical information:  1. Blood Pressure:						
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2. Current Weight		taken	1:			
3. Transferrin or Iron Saturation:         9k         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:           8. Current (if applicable) Hemoglobin Level:         g/dL         Date taken:           8. Glomerular Filtration Rate:         mL/min or Serum Creatinine:         mg/dL         Date taken:           9. Glomerular Filtration Rate:         mL/min or Serum Creatinine:         mg/dL         Date taken:           10. If s 18 years – document physician specialty:         Hematology         Neptrology         Other:           11. Chemotherapy Agents:         Serumia Due to Chemotherapy:         Others:           12. Date of most recent treatment:         Anticipated Juration of treatment:         For Anemia Due to Zidovudine for Treatment of HIV:           13. Weekly zidovudine dose:         mg/ week           14. Erythropoietin Level:         mUnits/mL bate taken:           15. Is the patient having symptoms due to the decrease in Hemoglobin?         Yes (Swint documentation)         No           16. What week of Hepatitis C treatment						
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6. Folate (folic acid) Level:	4. Ferritin Level: ng/mL Date	taken	1:			
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8. Current (if applicable) Hemoglobin Level:	6. Folate (folic acid) Level: Date	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: Anticipated duration of treatment:  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:   No  18. If yes, document type of surgery: and Anticipated Surgery Date:	7. Pre-Treatment Hemoglobin Level:g/dL Date	Date taken:				
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