**Fax completed prior authorization request form to** 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/chp-forproviders/pharmacy

# Erythropoiesis Stimulating Agents
# Pharmacy Prior Authorization Request Form

**Do not copy for future use. Forms are updated frequently**

**REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis**

| **Member Information** | | | |
|---|---|---|---|
| Member Name (first & last): | Date of Birth: | Gender: ☐ Male ☐ Female | Height: |
| Member ID: | City: | State: | Weight: |

| **Prescribing Provider Information** | | | |
|---|---|---|---|
| Provider Name (first & last): | Specialty: | NPI# | DEA# |
| Office Address: | City: | State: | Zip Code: |
| Office Contact: | Office Phone | Office Fax: | |

| **Dispensing Pharmacy Information** | | |
|---|---|---|
| Pharmacy Name: | Pharmacy Phone: | Pharmacy Fax: |

**Requested Medication Information**

| **Preferred Agent:** | ☐ **Retacrit** | | | | |
|---|---|---|---|---|---|
| **Non-Preferred Agents:** | ☐ Epogen | ☐ Procrit | ☐ Aranesp | ☐ Mircera | ☐ Other, please specify: |

| For non-preferred agents ONLY: Did member have trial and failure with Retacrit? | ☐ Yes | ☐ No | | |
|---|---|---|---|---|
| Are there any contraindications to formulary medications? If yes, please specify: | ☐ Yes | ☐ No | ☐ New request | ☐ Continuation of therapy request |

| ICD-10 Code: | Diagnosis: | Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes No |
|---|---|---|

| Directions for Use: | Strength: | | Dosage Form: |
|---|---|---|---|
| | Quantity: | Day Supply: | Duration of Therapy/Use: |

**Turn-Around Time for Review**

| ☐ Standard – (24 hours) | ☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: ______________________ |
|---|---|

**Clinical Information**

| Does member have uncontrolled HTN? | ☐ Yes | ☐ No | Is reticulocyte Hgb content >29 pg? | ☐ Yes | ☐ No |
|---|---|---|---|---|---|
| Is serum ferritin ≥100 ng/mL AND transferrin saturation (iron saturation) ≥20%? | | | | ☐ Yes | ☐ No |

**Additional Criteria Based on Indication**

**☐ Anemia due to Chronic Kidney Disease**

| Is Hgb <10 g/dL within the last 2 weeks? | ☐ Yes | ☐ No |
|---|---|---|

**☐ Renewal Request ONLY**

| Is member an ADULT on HD with Hgb <11 g/dL within last 2 weeks? | ☐ Yes | ☐ No | Is member an ADULT NOT on HD with Hgb <10 g/dL within last 2 weeks? | ☐ Yes | ☐ No |
|---|---|---|---|---|---|
| Is member a PEDIATRIC with Hgb <12 g/dL within last 2 weeks? | | | | ☐ Yes | ☐ No |

**☐ Anemia due to Cancer Chemotherapy**

| Is anemia due to concomitant myelosuppressive chemotherapy? | ☐ Yes | ☐ No | Is diagnosis non-myeloid malignancy such as solid tumor AND expected outcome is | ☐ Yes | ☐ No |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| | | | not a cure? | | |
| Is there a minimum of TWO additional months of planned chemotherapy? | ☐ Yes | ☐ No | Was Hgb <10 g/dL within last 2 weeks? | ☐ Yes | ☐ No |
| ☐ **Renewal Request ONLY** | | | | | |
| Is Hgb <11 g/dL within last 2 weeks? | | | | ☐ Yes | ☐ No |
| ☐ **Anemia with HIV Member Receiving Zidovudine** | | | | | |
| Is Zidovudine dose ≤4200 mg/week? | ☐ Yes | ☐ No | Are erythropoietin levels ≤ 500 IU/L? | ☐ Yes | ☐ No |
| Was Hgb <10 g/dL within the last 2 weeks? | | | | ☐ Yes | ☐ No |
| ☐ **Renewal ONLY** | | | | | |
| Was Hgb <11 g/dL within the last 2 weeks? | | | | ☐ Yes | ☐ No |
| ☐ **Reducing Transfusions in Elective Non-Cardiac Non-Vascular Surgery** | | | | | |
| Was Hgb >10 g/dL AND ≤13 g/dL within 30 days prior to planned surgery date? | ☐ Yes | ☐ No | Is member at high risk for perioperative blood loss? | ☐ Yes | ☐ No |
| Is member unable or unwilling to donate autologous blood preoperatively? | | | | ☐ Yes | ☐ No |
| ☐ **Anemia Associated with Myelodysplastic Syndrome** | | | | | |
| Are recent erythropoietin levels ≤500 IU/L? | ☐ Yes | ☐ No | Was Hgb <10 g/dL within last 2 weeks? | ☐ Yes | ☐ No |
| ☐ **Renewal Request ONLY** | | | | | |
| Was hemoglobin <12 g/dL within last 2 weeks? | | | | ☐ Yes | ☐ No |
| ☐ **Anemia in Hepatitis C** | | | | | |
| Is member receiving combination therapy with ribavirin AND interferon alpha? | ☐ Yes | ☐ No | Was Hgb <12 g/dL within last 2 weeks? | ☐ Yes | ☐ No |
| **Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.** | | | | | |
| | | | | | |

| |
|---|
| **Signature affirms that information given on this form is true and accurate and reflects office notes.** |
| **Prescribing Provider's Signature:** ______________________ **Date:** ____________ |

**<u>Please note: Incomplete forms or forms without the chart notes will be returned</u>**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 833-711-0776 to check the status of a request.



Proprietary