EPOGEN (epoetin alfa)

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Epogen
2. Have underlying causes of anemia been excluded an/or treated prior to initiating therapy (e.g., blood loss, folate deficiency, malnutrition, hemolysis)? Y N
3. Is the patient's blood pressure under control? Y N
4. Please document patient's pre-treatment Hemoglobin (Hb) level (g/dL). ____________
5. What is the diagnosis?

☐ Cancer Treatment-Related Anemia ☐ Anemia of Chronic Renal Failure ☐ Anemia in Surgery Patients

☐ Anemia in HIV patients ☐ Anemia of chronic disease ☐ Autoimmune hemolytic anemia

☐ Anemia associated with myelodysplastic syndrome ☐ Anemia of prematurity

☐ Anemia associated with management of Hepatitis C ☐ Anemia related to congestive heart failure (CHF)

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☐ Anemia in critically ill patients ☐ Anemia associated with frequent blood donation

☐ Anemia in trauma or surgery patients whose religious beliefs forbid the use of whole blood or blood components

☐ Red blood cell mobilization in patients with hemochromatosis ☐ Multiple myeloma

☐ Epidermolysis bulosa ☐ Chronic idiopathic myelofibrosis ☐ Other (specify): ____________________

6. Please document patient's serum ferritin level (ng/mL): ____________________

Please complete questions 7-9 ***only*** *if patient does not have serum ferritin level.*

7. Please document patient's serum iron level (mcg/dL): ____________________
8. Please document patient's Total Binding Capacity (TIBC) (mcg/dL): ____________________
9. What is the patient's % Transferring Saturation (TSAT)? *Formula:* (serum iron/TIBC) X 100 ______________
10. Is the patient currently on Epogen/Procrit therapy? Y N

    [If no, please only complete the section designated for the diagnosis.]

SECTION A: Cancer Treatment-Related Anemia

1. Does patient have risk factors/conditions that warrant the use of epoetin/darbepoetin? Y N
2. What is the risk factors/condition? ____
3. Is patient currently on supplemental iron? Y N
4. Please document the prescriber's target Hb (g/dL level): ______________________________

SECTION B: Anemia of Chronic Renal Failure

1. Is patient currently on supplemental iron? Y N
2. Please document the prescriber's target Hb (g/dL level): ______________________________

SECTION C: Anemia in Surgery Patients

1. Is the surgery cardiac or vascular? Y N
2. Is the epoetin use related to autologous blood donation? Y N
3. Is patient currently on supplemental iron?
4. Please document the prescriber's target Hb (g/dL level): ______________________________

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SECTION D: Anemia in HIV Patients

		Y	N
1.	Is patient currently on supplemental iron?	Y	N
2.	Is the patient receiving zidovudine (Retrovir, AZT)?	Y	N

3. If patient is receiving zidovudine, what is the weekly dose (mg)? ______________________

Comments:

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I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::