Prior Authorization Criteria Form

ARKANSAS BLUE CROSS BLUE SHIELD
Medi-Pak Rx (PDP), Medi-Pak Advantage (PFFS), and Medi-Pak Advantage - St. Vincent (PPO)

Procrit & Epogen (Medicare Prior Authorization)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Procrit and Epogen (Medicare Prior Authorization).

<table>
<thead>
<tr>
<th>Drug Name (select from list of drugs shown)</th>
<th>Procrit (epoetin alfa)</th>
<th>Epogen (epoetin alfa)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
</table>
Patient Name: [Blank]
Patient ID: [Blank]
Patient Group No.: [Blank]
Patient DOB: [Blank]

<table>
<thead>
<tr>
<th>Prescribing Physician</th>
</tr>
</thead>
</table>
Physician Name: [Blank]
Physician Phone: [Blank]
Physician Fax: [Blank]
Physician Address: [Blank]
City, State, Zip: [Blank]

<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>ICD Code:</th>
</tr>
</thead>
</table>

Please circle the appropriate answer for each applicable question.

1. Is therapy requested for the treatment of anemia in a patient with chronic renal failure? [Y N]
   [If no, skip to question 3.]

2. Is the patient currently undergoing dialysis? [Y N]
   [If yes, no further questions.]

3. Is therapy furnished “incident to” physician services (i.e., drug is purchased by the physician and then administered by the physician or under the physician’s direct supervision)? [Y N]

4. Is the patient scheduled to undergo an elective noncardiac, nonvascular surgery? [Y N]
   [If no, skip to question 6.]

5. Does the patient meet ALL of the following criteria for use related to surgery? [Y N]
   - pretreatment hemoglobin is greater than 10 to less than or equal to 13 g/dL
   - patient is at high-risk for perioperative blood loss
   - patient will receive concomitant iron supplementation
<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the patient received 12 weeks of therapy with epoetin alfa?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If no, skip to question 11.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is renewal of therapy requested for a patient with myelodysplastic syndrome (MDS)?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>(If no, skip to question 9.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient meet BOTH criteria for continued use of epoetin alfa for MDS?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>- hemoglobin is 12 g/dL or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- hemoglobin has increased 1g/dL or more in response to treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If yes, skip to question 20.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If no, no further questions.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is renewal of therapy requested for one of the following diagnoses?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>- chronic kidney disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- non-myeloid, non-curate malignancy currently treated with chemotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- anemia secondary to treatment with zidovudine in HIV-infected patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If no, no further questions.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient meet BOTH criteria for continued use of epoetin alfa?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>- hemoglobin is 12 g/dL or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- hemoglobin has increased 1g/dL or more in response to treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If yes, skip to question 19.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If no, no further questions.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have chronic kidney disease?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>(If yes, skip to question 18.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have a diagnosis of myelodysplastic syndrome (MDS)?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>(If no, skip to question 14.)</td>
<td></td>
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</tr>
<tr>
<td>Does the patient meet BOTH criteria for initial use in MDS?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>- pretreatment serum erythropoietin level is 500 mU/mL or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- pretreatment hemoglobin is 10 g/dL or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If yes, skip to question 20.)</td>
<td></td>
<td></td>
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<tr>
<td>(If no, no further questions.)</td>
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<tr>
<td>Is epoetin alfa requested for a patient with HIV-related anemia that is secondary to treatment with zidovudine?</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>(If no, skip to question 16.)</td>
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<tr>
<td>Is the patient currently receiving antiretroviral therapy?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>(If yes, skip to question 18.)</td>
<td></td>
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<tr>
<td>(If no, no further questions.)</td>
<td></td>
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</tr>
<tr>
<td>Does the patient have anemia secondary to chemotherapy for a non-myeloid, non-curative malignancy?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>(If no, no further questions.)</td>
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<tr>
<td>Is the patient currently receiving myelosuppressive chemotherapy?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>(If no, no further questions.)</td>
<td></td>
<td></td>
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<tr>
<td><strong>18.</strong> Does the patient have a PRETREATMENT hemoglobin 10 g/dL or less?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>[If no, no further questions.]</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>19.</strong> Have the iron stores been evaluated and does one of the following criteria apply?</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>- serum ferritin concentration 100 mcg/L or more and transferrin saturation is 20% or more OR</td>
<td></td>
<td></td>
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<tr>
<td>- patient is receiving iron supplementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[If no, no further questions.]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>20.</strong> Does the patient have either one of the following contraindications or exclusions to the use of Procrit:</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>- uncontrolled blood pressure, OR</td>
<td></td>
<td></td>
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<tr>
<td>- history of pure red cell aplasia</td>
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</tbody>
</table>

**Comments:** _______________________________

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

**Prescriber (Or Authorized) Signature and Date**