



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Procrit and 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).

Drug Name (select from list of drugs shown)

Epogen (epoetin alfa)

Procrit (epoetin alfa)

Patient Information

Patient

Name: _____

Patient ID: _____

Patient

Group No.: _____

Patient

DOB: _____

Prescribing Physician

Physician

Name: _____

Physician

Phone: _____

Physician

Fax: _____

Physician

Address: _____

City, State,

Zip: _____

Diagnosis: _____

ICD

Code: _____

Please circle the appropriate answer for each applicable question.

- | | | | |
|----|--|---|---|
| 1. | Does the patient have a diagnosis of uncontrolled hypertension?
[If the answer to this question is yes, then no further questions.] | Y | N |
| 2. | Does the patient have a diagnosis of anemia of chronic disease?
[If the answer to this question is yes, then may skip to question 8.] | Y | N |
| 3. | Does the patient have a diagnosis of anemia associated with
management of hepatitis C (with ribavirin and interferon alfa, or,
ribavirin and peginterferon alfa)?
[If the answer to this question is yes, then may skip to question 8.] | Y | N |
| 4. | Is the anemia of the patient associated with myelodysplastic
syndrome?
[If the answer to this question is no, then may skip to question 6.] | Y | N |
| 5. | Does the patient now or at the start of therapy have a serum
epoetin level less than or equal to 500 U/L?
[If the answer to this question is yes, then may skip to question 8. If the answer is no, then no further
questions.] | Y | N |
| 6. | Does the patient have a diagnosis of human immunodeficiency
virus (HIV) infection?
[If the answer to this question is no, then may skip to question 9.] | Y | N |



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7. Is the patient currently taking a medication regimen with zidovudine less than or equal to 4200 mg/week? Y N
[If the answer to this question is no, then no further questions.]
8. Does the patient have pre-treatment hemoglobin level less than 12 g/dL? Y N
[If the answer to this question is yes, then may skip to question 25. If the answer is no, then no further questions.]
9. Is the patient having elective, non-cardiac, non-vascular surgery? Y N
[If the answer to this question is no, may skip to question 13.]
10. Is the patient at high risk for perioperative blood loss? Y N
[If the answer to this question is no, then no further questions.]
11. Does the patient have pre-treatment hemoglobin level greater than 10 g/dL but less than or equal to 13 g/dL? Y N
[If the answer to this question is no, then no further questions.]
12. Is the use related to autologous blood donation? Y N
[If the answer to this question is no, then may skip to question 25. If the answer is yes, then no further questions.]
13. Does the patient have a diagnosis of metastatic, non-myeloid malignancies? Y N
[If the answer to this question is no, then may skip to question 18.]
14. Is the patient currently receiving myelosuppressive therapy? Y N
[If the answer to this question is no, then no further questions.]
15. Is the patient receiving chemotherapy for curative intent? Y N
[If the answer to this question is yes, then no further questions.]
16. Does the patient have pre-treatment hemoglobin level less 10 g/dL or 10-11 g/dL with clinical symptoms? Y N
[If the answer to this question is no, then no further questions.]
17. Will epoetin alfa be discontinued after the completion of a chemotherapy course? Y N
[If the answer to this question is yes, then may skip to question 25. If the answer is no, then no further questions.]
18. Does the patient have a diagnosis of chronic renal failure? Y N
[If the answer to this question is no, then no further questions.]
19. Is the patient on chronic dialysis therapy? Y N
[If the answer to this question is no, then may skip to question 21.]
20. Does the patient have pre-treatment hemoglobin level less than 12 g/dL? Y N
[If the answer to this question is yes, then may skip to question 22. If the answer is no, then no further questions.]
21. Does the patient have pre-treatment hemoglobin less than 10 g/dL? Y N
[If the answer to this question is no, then no further questions.]
22. Was the iron status (transferrin saturation) of the patient evaluated at baseline and will be monitored throughout the therapy? Y N
[If the answer to this question is no, then no further questions.]
23. Is the transferrin saturation of the patient greater than or equal to 20%? Y N
[If the answer to this question is yes, then may skip to question 25.]
24. Will the patient receive iron supplementation? Y N
[If the answer to this question is no, then no further questions.]
25. Will the hematology labs (hemoglobin and hematocrit) of the patient be monitored throughout the therapy? Y N
[If the answer to this question is no, then no further questions.]
26. Has the patient received epoetin alfa within the previous month? Y N
[If the answer to this question is no, then may skip to question 34.]
27. Has the patient completed at least 8 weeks of epoetin alfa Y N



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therapy?

[If the answer to this question is no, then may skip to question 29.]

28. Compared to pretreatment baseline, has the patient shown an objective clinical response (e.g., hemoglobin rise greater than or equal to 1 g/dL and/or hematocrit rise greater than or equal to 3%) to an appropriate dose/dose increase and duration of therapy? Y N

[If the answer to this question is no, then no further questions.]

29. Is the current hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 12 g/dL? Y N

[If the answer to this question is no, then may skip to question 32.]

30. Was the previous hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 12 g/dL? Y N

[If the answer to this question is yes, then no further questions.]

31. Will the prescriber be holding dose administration until the hemoglobin level is less than 12g/dL? Y N

[If the answer to this question is yes, then may skip to question 34. If the answer is no, then no further questions.]

32. Has the hemoglobin of the patient increased more than 1 g/dL in any two week period or 3 g/dL during one month? Y N

[If the answer to this question is no, then may skip to question 34.]

33. Will the prescriber be reducing dose to avoid rapid rise in hemoglobin level? Y N

[If the answer to this question is no, then no further questions.]

34. Will the blood pressure of the patient be monitored throughout therapy? Y N

[If the answer to this question is no, then no further questions.]

35. Will the patient be monitored for the occurrence of cardiac and thrombotic events? Y N

Comments:

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

Prescriber (Or Authorized) Signature and Date