WELLPOINT nextRx

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Epogen® & Procrit® (epoetin alfa) Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at (800) 601- 4829

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
□ Epogen (epoetin alfa) □ Procrit (epoetin alfa)	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes □ No If request is for Epogen, has the patient tried, failed or is intolerant to Procrit? If yes, please provide trial date(s) and/or intolerance: _____.

□ Yes □ No Is patient continuing therapy with the requested drug?

□ Yes □ No Does Hgb exceed 12 g/dL? Please specify current Hgb: _____g/dL

□ Yes □ No Are iron stores (including transferrin saturation and ferritin) adequately maintained and monitored periodically during therapy?

ALL of the following criteria must be met:

□ Yes □ No Patient has hemoglobin (Hgb) levels less than 10 g/dL, prior to initiation of therapy (unless otherwise specified below)

□ Yes □ No Patient's iron status, prior to initiation of therapy, including transferrin saturation or serum ferritin or bone marrow, is evaluated and the transferrin saturation is at least 20% or ferritin is least 80 ng/mL or evidence of bone marrow demonstrates adequate bone marrow stores.

□ Yes □ No Does the patient have hypertension?

□ Yes □ No If yes, is the patient's hypertension adequately controlled?
Blood pressure must be adequately controlled before initiation of therapy and closely monitored and controlled during therapy

Patient has anemia associated with: (please respond to all)

□ Yes □ No Chronic renal failure with the need to achieve and maintain hemoglobin levels within the range of 10 to 12 g/dL

□ Yes □ No Cancer chemotherapy

□ Yes □ No Is chemotherapy planned for a minimum of 2 months?

□ Yes □ No Patient has a diagnosis of non-myeloid cancer and anticipated outcome is not cure

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Patient Name: _____ **Patient ID#:** _____

□ Yes □ No	Myelodysplastic syndrome with endogenous erythropoietin level is ≤ 500 mUnits/mL
□ Yes □ No	Zidovudine therapy in HIV-infected patients
	□ Yes □ No Patient's endogenous serum erythropoietin level is ≤ 500 mUnits/mL and the dose of zidovudine is ≤ 4200 mg/week
□ Yes □ No	Elective, non-cardiac non-vascular surgery to reduce the need for allogeneic blood transfusions when the patient meets the following:
	□ Yes □ No Patient's hemoglobin levels are > 10 to ≤ 13 g/dL
	□ Yes □ No Patient at high risk for perioperative transfusions with significant, anticipated blood loss
	□ Yes □ No Patient is unable or unwilling to donate autologous blood
	□ Yes □ No Antithrombotic prophylaxis has been considered
□ Yes □ No	Hepatitis C virus infection
	□ Yes □ No Patient is being concomitantly treated with the combination of ribavirin and interferon alfa, or ribavirin and peg-interferon alfa
□ Yes □ No	Myelosuppressive drugs (e.g. disease modifying anti-rheumatic drugs) known to produce anemia in patients with a diagnosis of chronic inflammatory disease
□ Yes □ No	Patient is following allogeneic bone marrow transplantation

9. PHYSICIAN SIGNATURE

_____ _____
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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