CONTAINS CONFIDENTIAL PATIENT INFORMATION

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**
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 Individual is continuing therapy with the requested drug **If yes:**
- ☐ Yes ☐ No The hemoglobin (Hgb) level exceeds 11.0 g/dL
  Please specify current Hgb: ________g/dL
- ☐ Yes ☐ No Iron stores (including transferrin saturation and ferritin) are adequately maintained and monitored periodically during therapy

☐ Yes ☐ No Individual has Hgb levels less than 10.0 g/dL, prior to initiation of therapy

☐ Yes ☐ No Individual's iron status, prior to initiation of therapy, includes transferrin saturation or ferritin or bone marrow evaluation **If yes:**
- ☐ Yes ☐ No Transferrin saturation is at least 20%
- ☐ Yes ☐ No Ferritin is at least 80ng/mL
- ☐ Yes ☐ No Bone marrow demonstrates adequate iron stores

☐ Yes ☐ No The individual has hypertension **If yes:**
- ☐ Yes ☐ No Blood pressure will be adequately controlled before initiation of therapy and closely monitored and controlled during therapy

Diagnosis: (please respond to all)

☐ Yes ☐ No Anemia associated with chronic kidney disease
- ☐ Yes ☐ No Individual is on dialysis
  - ☐ Yes ☐ No **If yes,** Individual is using the requested medication to achieve and maintain hemoglobin levels within the range of 10.0 to 11.0 g/dL
  - ☐ Yes ☐ No **If no,** Individual is using the requested medication to achieve and maintain hemoglobin levels of 10.0g/dL

☐ Yes ☐ No Anemia associated with cancer chemotherapy
- ☐ Yes ☐ No Chemotherapy is planned for a minimum of 2 months
- ☐ Yes ☐ No Patient has a diagnosis of non-myeloid cancer and anticipated outcome is not cure

☐ Yes ☐ No Myelodysplastic syndrome with endogenous erythropoietin level < 500mUnits/mL

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Patient Name: ___________________________________ **Patient ID#:** _________________________________

☐ Yes ☐ No Zidovudine therapy for human immunodeficiency virus (HIV)-infected patients
- ☐ Yes ☐ No Individual's endogenous serum erythropoietin level is less than or equal to 500 mUnits/mL and the dose of zidovudine is less than or equal to 4200 mg/week

☐ Yes ☐ No Hepatitis C virus infection
- ☐ Yes ☐ No Individual 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 individuals with a diagnosis of chronic inflammatory disease

☐ Yes ☐ No Individual is following allogeneic bone marrow transplantation

☐ 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 greater than 10.0 to less than or equal to 13.0g/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 Prior to initiation of therapy, evaluation of the patient's iron status reveals one of the following (please indicate):
  - ☐ Yes ☐ No Transferrin saturation is at least 20%
  - ☐ Yes ☐ No Ferritin is at least 80ng/mL
  - ☐ Yes ☐ No Bone marrow demonstrates adequate iron stores
- ☐ Yes ☐ No Patient has hypertension **If yes:**
  - ☐ Yes ☐ No Blood pressure will be adequately controlled before initiation of therapy and closely monitored and controlled during therapy

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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