BlueChoice®
HealthPlan of South Carolina

Medicaid

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Epogen® & Procrit® (epoetin alfa)

Complete form in its entirety and fax to:
Prior Authorization of Benefits (PAB) Center at (866) 807- 6241

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

ONE of the following criteria must be met:

□ Yes □ No Patient has anemia of chronic renal failure

□ Yes □ No Treatment of anemia induced by concomitantly administered chemotherapy known to produce anemia, in patients with a diagnosis of any of the following:

- □ Yes □ No Cancer, **excluding** acute leukemia
- □ Yes □ No Chronic inflammatory disease

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Medicaid managed care administered by WellPoint Partnership Plan, LLC, an independent company.

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Patient Name: ____________________________________ **Patient ID#:** __________________________________

- ☐ Yes ☐ No Patient has Myelodysplastic syndrome with endogenous erythropoietin level is ≤ 500 mUnits/mL
- ☐ Yes ☐ No Treatment of anemia related to therapy with zidovudine 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 Treatment of preoperative anemia to reduce the need for allogeneic blood transfusions when the patient meets the following:
  - ☐ Yes ☐ No Patient's hemoglobin > 10 to ≤ 13 g/dL
  - ☐ Yes ☐ No Patient is scheduled to undergo elective, noncardiac, nonvascular surgery
  - ☐ 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 Patient has 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 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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