

# OPTIMA HEALTH PLAN

## PHARMACY PRIOR AUTHORIZATION REQUEST FORM\*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff and faxed to 757-552-7516 or 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.

**Circle Drug Name: Aranesp, Epogen, and Procrit (This form is to be completed only if the patient is self-administering)**

- The FDA has placed a Black Box Warning on all Erythropoietin Stimulating Agents (ESA).
- This warning is to advise of the increased risk of serious life threatening side effects and mortality with the use of these agents in anemic cancer patients not receiving chemotherapy and in chronic kidney disease patients with hemoglobin levels greater than 12g/dL.
- Aranesp, Epogen, or Procrit should not be initiated when hemoglobin levels are greater than 12g/dL, and should be dosed to maintain a therapeutic range of 11-12g/dL.

**Please complete below:**

Diagnosis: **Anemia associated with:**

- |                                                |                                                                            |
|------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> Heart Failure         | <input type="checkbox"/> Preoperative Use in patients undergoing surgery   |
| <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Hepatitis C treated with ribavirin and interferon |
| <input type="checkbox"/> Chemotherapy-induced  | <input type="checkbox"/> Chronic anemia associated with malignancy         |
| <input type="checkbox"/> Chronic Renal Failure | <input type="checkbox"/> Prematurity                                       |
| <input type="checkbox"/> Rheumatoid Arthritis  | <input type="checkbox"/> Sickle Cell Anemia                                |

**\*\* NOTE: ESAs should not be used to achieve hemoglobin levels >12g/dL nor should they be used in cancer patients not receiving chemotherapy\*\***

**All boxes must be checked to qualify (Submit lab test results for review)**

- Patient's most recent hemoglobin level is less than 11g/dL. Hg = \_\_\_\_\_
- Patient's serum ferritin is at least 100ng/mL. Ferritin = \_\_\_\_\_

- .....
- Patient's most recent transferrin saturation is at least 20%

**OR**

- Patient's transferrin saturation is between 10% - 19% and patient is receiving oral Iron supplementation OR Patient's transferrin saturation is <10% and patient is receiving IV Iron supplementation

- .....
- Drug and dosage regimen prescribed: \_\_\_\_\_
- Anticipated length of therapy: \_\_\_\_\_
- Therapies tried: \_\_\_\_\_

FOR MEDICARE ONLY- the following conditions will **not** be covered by Medicare: Anemia in cancer or cancer treatment due to vitamin deficiencies, hemolysis, bleeding or bone marrow fibrosis not related to chemotherapy, anemia associated with chemotherapy for CML or AML, anemia associated with radiotherapy without concomitant chemotherapy, prophylactic use to prevent chemotherapy induced anemia or tumor hypoxia, patients with EPO-type resistance, patients with treatments including angiogenic drugs and anemia of chronic disease.

Patient: \_\_\_\_\_

Member Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Anticipated length of therapy: \_\_\_\_\_ Anticipated length of therapy: \_\_\_\_\_ Physician's

Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Pharmacy Tel # \_\_\_\_\_