OPTUMRx®

Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Optima Health

Procrit® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Anemia associated with hepatitis C treated with ribavirin and interferon
❑ Anemia associated with HIV/AIDS and receiving zidovudine
❑ Anemia associated with myelodysplastic syndrome (MDS)
❑ Anemia associated with prematurity
❑ Anemia associated with sickle cell anemia
❑ Anemia associated with surgery undergoing elective therapy
❑ Other diagnosis: _______________________________________ ICD-10 Code(s): _________________________________

Clinical Information:

Document the patient's most recent hemoglobin level: _______________
Submission of lab/tests indicating patient's most recent hemoglobin level is required

Select if the patient has the following to indicate adequate iron stores to support erythropoiesis:
❑ Patient's serum ferritin level is greater than or equal to 100 ng/mL
❑ Patient's most recent transferrin saturation is greater than or equal to 20%
❑ Documentation of ESA drug and dosage regimen prescribed
❑ Documentation of anticipated length of ESA therapy
❑ Documentation if iron therapy is present
Submission of lab test results is required

For anemia associated with hepatitis C treated with ribavirin and interferon, also answer the following:

Is the patient's hemoglobin level less than or equal to 10 g/dL? ❑ **Yes** ❑ **No**

Is the patient unresponsive to a 200 mg/day reduction of ribavirin? ❑ **Yes** ❑ **No**

Is the patient symptomatic due to one of the following conditions: Anemia, cirrhosis, HIV coinfection, or liver transplant? ❑ **Yes** ❑ **No**

For anemia associated with HIV/AIDS and receiving zidovudine, also answer the following:

Is the patient's endogenous erythropoietin level less than 500 mU/mL? ❑ **Yes** ❑ **No**
Submission of lab results/tests is required

Is the patient receiving a dose of zidovudine of less than or equal to 4200 mg/week? ❑ **Yes** ❑ **No**

For anemia associated with myelodysplastic syndrome, also answer the following:

Is the patient's endogenous erythropoietin level less than 500 mU/mL? ❑ **Yes** ❑ **No**
Submission of lab results/tests is required

Is Procrit being used in combination with a granulocyte colony stimulating factor (G-CSF)? ❑ **Yes** ❑ **No**

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

OPTUMRx® Optima Health

Procrit® Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

For anemia associated with prematurity, also answer the following:

Is the patient's birth weight less than 1500 grams? ❑ **Yes** ❑ **No**

Is the patient's gestational age less than 33 weeks? ❑ **Yes** ❑ **No**

Is Procrit being used in combination with iron supplementation? ❑ **Yes** ❑ **No**

For anemia associated with surgery undergoing elective therapy, also answer the following:

Select if the patient is undergoing one of the following elective therapies:

- ❑ Noncardiac surgery
- ❑ Nonvascular surgery

Are the patient's hemoglobin (Hgb) levels greater than 10 but less than or equal to 13 g/dL? ❑ **Yes** ❑ **No**

Submission of lab results/tests is required

Medication being provided by: (Please check applicable box below)

❑ Physician's office ❑ PropriumRx ❑ Specialty Pharmacy (specify name): ___________________________

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: ____ **Date:** ____________________________________

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**