

**ERYTHROPOIESIS
STIMULATING PROTEINS
PRIOR AUTHORIZATION FORM**



Keystone First

PERFORMRxSM
Next Generation Pharmacy Benefits

(form effective 1/1/20)

Fax to PerformRxSM at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION		
<input type="checkbox"/> New <input type="checkbox"/> Renewal	# pages in this request:	Additional information (PA#: _____)
Office Contact Name:	Phone:	

PATIENT INFORMATION		
Name:	Patient ID #:	Date of birth:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION		
Prescriber name:	Specialty:	
NPI#:	OR MA Provider ID #	State license #:
Prescriber address:	Suite #:	City/state/zip:
Phone:	Fax:	
Long-term care facility (if applicable) contact name:	Phone:	

MEDICAL INFORMATION	
1. Drug Requested: <input type="checkbox"/> Aranesp (Preferred) <input type="checkbox"/> Epogen (Preferred) <input type="checkbox"/> Mircera (Preferred) <input type="checkbox"/> Procrit (Non-preferred) <input type="checkbox"/> Retacrit (Preferred) Epogen/Procrit/Retacrit strength: _____ units/mL Aranesp/Mircera strength: _____ mcg/_____ mL Choose: <input type="checkbox"/> Syringe or <input type="checkbox"/> Vial	
2. Dose: _____ Directions: _____	Quantity: _____ Refills: _____
3. Diagnosis – Anemia due to _____ Diagnosis Code: _____ (required)	
4. Is this a new start for the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No – Document date treatment was initiated: _____	
5. PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication): Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name: Pharmacy Phone #: _____ Pharmacy Fax #: _____ <input type="checkbox"/> I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

Epogen Requests:

1. Has the patient tried and failed any of the Preferred agents (Procrit and Aranesp)? Yes (Submit documentation) No

2. Does the patient have a contraindication or intolerance to either Preferred agent? Yes (Submit documentation) No

All Requests: Please complete the following clinical information:

1. Blood Pressure: _____	Date taken: _____
2. Current Weight: _____ pounds or _____ kilograms	Date taken: _____
3. Transferrin or Iron Saturation: _____ %	Date taken: _____
4. Ferritin Level: _____ ng/mL	Date taken: _____
5. Vitamin B12 (cobalamin) Level: _____	Date taken: _____
6. Folate (folic acid) Level: _____	Date taken: _____
7. Pre-Treatment Hemoglobin Level: _____ g/dL	Date taken: _____
8. Current (if applicable) Hemoglobin Level: _____ g/dL	Date taken: _____

For Anemia Due to Chronic Kidney Disease:

9. Glomerular Filtration Rate: _____ mL/min or Serum Creatinine : _____ mg/dL Date taken: _____

10. If ≤ 18 years – document physician specialty: Hematology Nephrology Other: _____

For Anemia Due to Chemotherapy:

11. Chemotherapy Agents: _____

12. Date of most recent treatment: _____ Anticipated duration of treatment: _____

For Anemia Due to Zidovudine for Treatment of HIV:

13. Weekly zidovudine dose: _____ mg/ week

14. Erythropoietin Level: _____ mUnits/mL Date taken: _____

For Anemia Due to Ribavirin for Treatment of Hepatitis C:

15. Is the patient having symptoms due to the decrease in Hemoglobin? Yes (Submit documentation) No

16. What week of Hepatitis C treatment is the patient in currently? Week: _____

For the Reduction of Allogeneic Blood Transfusion in Surgery:

17. Is the patient undergoing elective, non-cardiac, non-vascular surgery? Yes No

18. If yes, document type of surgery: _____ and Anticipated Surgery Date: _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

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