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Erythropoiesis Stimulating Agents Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk at 1-800-454-3730.

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**
___	___	___	Specify: ___

7. Diagnosis: ___

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization (PA) is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia. Payment for non-preferred erythropoiesis stimulating agents will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s).

Preferred	**Nonpreferred**
☐ Epogen	☐ Aranesp
☐ Retacrit	☐ Mircera
	☐ Procrit

Hemoglobin: ___%; Lab test date: ___ (Lab test date must be within four weeks of the PA request date.)
Transferrin saturation: ___ Ferritin: ___ Lab test date: ___ (Lab test must be within 3 months of the PA request date.)
Is the patient currently on dialysis? ☐ Yes ☐ No

Is the patient on concurrent therapeutic iron therapy ☐ Yes ☐ No
If yes, what is the current drug name, strength and dose? ____
Does the patient have active gastrointestinal bleeding? ☐ Yes ☐ No; If yes, what is the current treatment?
____
Does the patient have hemolysis? ☐ Yes ☐ No
Does the patient have a vitamin B-12, iron or folate deficiency? ☐ Yes ☐ No
Previous erythropoiesis stimulating agent therapy (include drug name(s), strength and exact date ranges) :
____
Reason for use of nonpreferred drug requiring prior approval:____

Attach lab results and other documentation as necessary.

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.