Neighborhood Health Plan of Rhode Island
Prior authorization Form
Non-Chemotherapy Induced Anemia
Epogen®/Procrit® (epoetin alpha)

Customer Service (401)-459-6020, Fax (401)-459-6023

Due to safety concerns, only FDA approved indications will be covered for NHPRI members. Product Package Insert recommended dosing/administration information is used as guidelines for coverage.
****DO NOT USE THIS FORM FOR ANEMIA SECONDARY TO CHEMOTHERAPY****

Member Name (required) _____	**Member ID Number:** (required) | | | | | | | | |
Member Date of Birth: (required) / /	
Prescriber Name: (required)	**Contact Person at Office:**
Office Phone number: (required) **( ) -**	**Office Fax Number:** (required) **( ) -**

Prescriber Specialty: (Circle one) Hematologist Oncologist Nephrologist Other _____

INDICATIONS FOR USE (Please check appropriate box and fill in Levels and Date Drawn)

- ❑ **Patient is diagnosed with chronic renal failure** *AND*
  - Transferrin saturation is > 20%
  - Ferritin is > 100ng/mL
  - If a non-dialysis patient hemoglobin is <10g/dL **Hb Level**_____ **Date drawn**_____

Renewals: Patient's Hb is <12 g/dL **Hb Level** _____ **Date drawn**_____

- ❑ **Patient is HIV+ with anemia related to zidovudine therapy** *AND*
  - Endogenous serum erythropoietin level is ≤ 500 mUnits/mL
  - Dose of zidovudine is ≤ 4200 mg/week **Hb level** _____**Date drawn**_____

Renewals: Patient's Hb is <12 g/dL **Hb level**_____ **Date drawn** _____

- ❑ **To reduce the need for allogenic blood transfusions in anemic patient undergoing elective, non-cardiac, non-vascular surgery** *AND*
  - Hemoglobin is >10 to < 12 g/dL **Hb Level** _____ **Date drawn**_____

May not be administered to patients to target a hemoglobin of greater than 12 g/dL due to increased risk of death and cardiovascular events

If criteria are met NHPRI will authorize coverage of Epogen ®/Procrit® . ***Failure to provide dates/values of lab testing will result in NHPRI not paying for the ordered drug, and may delay delivery of the drug to patient.***

Initial approval will be for 4 weeks at which time patient should be evaluated for response to therapy. If patient is responding to therapy and continues to meet criteria, monthly approvals will be granted.

Medication Directions_____

PRESCRIBER SIGNATURE_____ DATE_____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.