

Neighborhood Health Plan of Rhode Island
Prior authorization Form
Chemotherapy Induced Anemia
Epogen® (epoetin alpha)
Customer Service (401)-459-6020, Fax (866)-423-0945

Epogen is the preferred epoetin alpha product. All requests will be authorized for Epogen unless a rationale for needing Procrit is provided in the box below.

Due to safety concerns, Neighborhood has implemented guidelines for ESA coverage, taking into consideration the clinical criteria established by CMS/ASH National Coverage Determination (NCD) and the expertise of local oncologists. Documentation of a Hb level ≤ 10 g/dL is required for initial coverage of ESA for chemotherapy induced anemia. ***Verification that Hb levels remain <12 g/dL will be required every 4 weeks.*** As with CMS guidelines, off-label indications will not be covered by NHPRI.

Member Name (required) _____	Member ID Number: (required) <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
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 _____

Please CHECK the appropriate boxes and fill out the following information:

DIAGNOSIS

- Pt is diagnosed with anemia secondary to myelosuppressive anticancer chemotherapy for solid tumors, multiple myeloma, lymphoma, OR lymphocytic leukemia and will start, or is currently undergoing, chemotherapy
- Patient is receiving post-chemotherapy treatment requested (within 8 weeks of stop date). Chemotherapy completed on (date) _____.

TREATMENT

Initial Therapy:

- Hb is ≤ 10 g/dL Hb level _____ Date labs drawn _____

Ongoing Maintenance Treatment:

- Hb is ≤ 12 g/dL and has not risen >1 g/dL in last 2 weeks Hb level _____ Date labs drawn _____

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

If approval criteria are met, Neighborhood will authorize coverage of **Epogen**® unless rationale is provided for needing Procrit®. **Failure to provide dates/values of lab tests may result in NHPRI not paying for the ordered drug, and may delay delivery of the drug to patient.**

Rationale for needing Procrit _____

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, 3 month approvals will be granted

Medication Directions _____
 Prescriber Signature _____ NPI _____ Date _____