

**Neighborhood Health Plan of Rhode Island  
Prior authorization Form**

**Chemotherapy Induced Anemia**

**Epogen®/Procrit® (epoetin alpha)**

Customer Service (401)-459-6020, Fax (866)-423-0945

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  $\leq 10$  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.

<b>Member Name</b> (required) _____	<b>Member ID Number:</b> (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>								
<b>Member Date of Birth:</b> (required)     /     /									
<b>Prescriber Name:</b> (required)	<b>Contact Person at Office:</b>								
<b>Office Phone number:</b> (required) (     ) -	<b>Office Fax Number:</b> (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  $\leq 10$  g/dL    Hb level \_\_\_\_\_    Date labs drawn \_\_\_\_\_

**Ongoing Maintenance Treatment:**

- Hb is  $\leq 12$  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 ®/Procrit® . **Failure to provide dates/values of lab tests 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 \_\_\_\_\_ NPI \_\_\_\_\_ DATE \_\_\_\_\_

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