

**Neighborhood Health Plan of Rhode Island**  
**Prior authorization Form**  
**Non-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, 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\*\***

<b>Member Name</b> (required) _____	<b>Member ID Number:</b> (required) _____ <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
<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 _____	

**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 ® unless rationale is provided for needing Procrit®.. **Failure to provide dates/values of lab testing 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 \_\_\_\_\_