

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

Non-Chemotherapy Induced Anemia

Epogen®/Procrit® (epoetin alpha)

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

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) _____ <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 _____									
INDICATIONS FOR USE (Please check appropriate box and fill in Levels and Date Drawn)									
<input type="checkbox"/> Patient is diagnosed with chronic renal failure AND									
<ul style="list-style-type: none"> • 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 _____									
<input type="checkbox"/> Patient is HIV+ with anemia related to zidovudine therapy AND									
<ul style="list-style-type: none"> • 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 _____									
<input type="checkbox"/> To reduce the need for allogenic blood transfusions in anemic patient undergoing elective, non-cardiac, non-vascular surgery AND									
<ul style="list-style-type: none"> • 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 _____ NPI _____ DATE _____

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