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.

These products are not indicated for the following patients: 1) patients that have an anticipated outcome of cure 2) patients with uncontrolled hypertension 3) patients with pure red cell aplasia (PRCA) that develops after treatment with any erythropoietin drug.

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. For renewals: Verification that Hb levels remain ≤11 g/dL will be required. As with CMS guidelines, off-label indications will not be covered by NHPRI.

Instructions: If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of the requested drug. Failure to fill out this form will result in a rejection of this medication at the pharmacy. Please complete this form and fax to: Neighborhood Customer Service at fax # 1-866-423-0945. To review the entire Neighborhood Formulary, please visit our website at: http://www.nhpri.org

Medication Requested: ___________________________ Strength: ________________ Is this a New Request or Renewal (Circle one)
Medication CPT Code: _______________ Medication Directions: __________________

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

**DIAGNOSIS**

- Patient 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 AND
  - Does patient have a minimum of two additional months of planned chemotherapy from request date? Yes or No
- Patient is receiving post-chemotherapy treatment (within 8 weeks of stop date). Chemotherapy completed on (date)____________________.

**TREATMENT**

Initial Therapy:
- Hb is <10 g/dL Hb level_____________ Date labs drawn_____________

RENEWALS:

Ongoing Maintenance Treatment:
- Hb is ≤11 g/dL and has not risen >1 g/dL in last 2 weeks Hb level_______ Date labs drawn__________

To ensure the claim is processed appropriately, please give the name of the facility, hospital, or office that will be supplying the drug Epogen: __________________________/NPI

ESA may not be administered to patients to target a hemoglobin level of greater than 11 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

Prescriber Signature______________________________ NPI_________________________ Date________________