# ARANESP, EPOGEN, OMONTYS, & PROCRIT

## Prior Authorization Form

**IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.**

Otherwise please return completed form to:

**UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC(8762) FAX 412-454-7722**

**THIS SECTION FOR PROVIDER USE ONLY— PLEASE TYPE OR PRINT NEATLY**

***Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.***

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|---|---|---|---|
| **Office Contact:** | | **Provider Specialty:** | |
| **Provider First Name:** | | **Provider Last Name:** | |
| **Provider Phone:** | | **Provider Fax:** | **Provider NPI #:** |
| **Patient Name:** | **Patient UPMC Health Plan ID Number:** | **Patient DOB:** | **Patient Weight:** |
| **Drug Requested:** ☐**Brand** ☐**Generic** | **Dose:** | **Frequency:** | **Qty Dispensed:** |

***Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.***

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| ☐**New Medication** ☐**Ongoing Medication** | **If Ongoing Provide Date Started:** | **If medication is ongoing, did the member show improvement while on therapy?** | ☐**Yes** ☐**No** |
| **Diagnosis:** | | **Date of diagnosis:** | |
| **Please indicate place of administration:** | ☐ Physician's Office<br>☐ Hospital/Clinic<br>☐ Dialysis Clinic<br>☐ Patient Home | **Will the drug be: (select one)**<br>☐ Billed directly by the provider via JCODE<br>JCODE: _____<br>☐ Billed by a pharmacy and delivered to the provider<br>☐ Billed by a pharmacy and delivered to the patient | |
| **Please provide hospital/facility name and address:** | | | |

### MEDICAL

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| **Anemia due to renal failure?** | ☐**Yes** ☐**No** | **If Yes, please complete the following:** | ☐**Acute** ☐**Chronic** |
| **Anemia due to End Stage Renal Disease (ESRD)?** | ☐**Yes** ☐**No** | **Indicate severity of renal failure:**<br>**Is member on renal dialysis:** | ☐**Yes** ☐**No** |
| **Non-myeloid Malignancy?** | ☐**Yes** ☐**No** | **If yes, please complete the following:**<br>**Is anemia due to iron or folate deficiency?** | ☐**Yes** ☐**No** |
| **Anemia due to chemotherapy?** | ☐**Yes** ☐**No** | **Is anemia due to Hemolysis?** | ☐**Yes** ☐**No** |
| | | **Is anemia due to GI bleed?** | ☐**Yes** ☐**No** |
| **HIV positive?** | ☐**Yes** ☐**No** | **If Yes, is patient receiving zidovudine?** | ☐**Yes** ☐**No** |
| **Anemia due to other cause?** | ☐**Yes** ☐**No** | **Please submit chart documentation indicating rationale for therapy and supportive lab values.** | |

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| **Is patient scheduled to undergo elective, noncardiac, or nonvascular surgery and at high risk for perioperative transfusions?** | | | ☐**Yes** ☐**No** |
| **Specify Hgb level (g/dL):** _____ **Date of test:** _____ | | **Does member have uncontrolled Hypertension?** | ☐**Yes** ☐**No** |
| **Is patient currently receiving iron supplement therapy** | ☐**Yes** ☐**No** | **Specify serum ferritin (mcg/L):** ☐**<100** ☐**100-200** ☐**>200**<br>**Specify serum transferrin saturation:** ☐**<20%** ☐**>20%** | |
| **Does patient have a known hypersensitivity to the product's active substance or excipients?** | ☐**Yes** ☐**No** | **If Yes, please specify reaction and rationale for decision to use product:** | |
| **What is the medication's starting dose?** | | **What is the medication's maintenance dose:** | |

### Authorization Reassessment

| Reassessment Period | Change in Hgb (g/dL) | Hgb (g/dL) and Test Date | Change in Hct | Pharmacist Adherence Evaluation |
|---|---|---|---|---|
| **1 Month** | | | | |
| **6 Month** | | | | |