

# ARANESP, EPOGEN, OMONTYS, & PROCRT

## 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.*

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: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Dose:	Frequency:	Qty Dispensed:
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New Medication <input type="checkbox"/> Ongoing Medication	If Ongoing Provide Date Started:	If medication is ongoing, did the member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	
Please indicate place of administration:	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Dialysis Clinic <input type="checkbox"/> Patient Home	<b>Will the drug be: (select one)</b> <input type="checkbox"/> Billed directly by the provider via JCODE JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Please provide hospital/facility name and address:			

**MEDICAL**

Anemia due to renal failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please complete the following:	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic
Anemia due to End Stage Renal Disease (ESRD)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate severity of renal failure: Is member on renal dialysis:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Non-myeloid Malignancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please complete the following: Is anemia due to iron or folate deficiency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia due to chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is anemia due to Hemolysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is anemia due to GI bleed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia due to other cause?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, is patient receiving zidovudine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is patient scheduled to undergo elective, noncardiac, or nonvascular surgery and at high risk for perioperative transfusions?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Specify Hgb level (g/dL): _____ Date of test: _____		Does member have uncontrolled Hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is patient currently receiving iron supplement therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify serum ferritin (mcg/L): <input type="checkbox"/> <100 <input type="checkbox"/> 100-200 <input type="checkbox"/> >200	Specify serum transferrin saturation: <input type="checkbox"/> <20% <input type="checkbox"/> >20%
Does patient have a known hypersensitivity to the product's active substance or excipients?	<input type="checkbox"/> Yes <input type="checkbox"/> 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				