Prior Authorization Request Form for Erythropoiesis Stimulating Agents

FAX this completed form to (844) 205-3386
OR Mail requests to: PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Does the member have a history of a contraindication to the requested medication?
☐ Yes
☐ No

Requests for all non-preferred Erythropoiesis Stimulating Agents: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Erythropoiesis Stimulating Agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*
☐ Yes
☐ No
Medication Taken Previously (start and end date and dose):_____
_____
_____
_____

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

INITIAL REQUEST:

- ☐ If not prescribed by the following specialist, (e.g., hematologist/oncologist, gastroenterologist, infectious disease specialist, nephrologist, surgeon, etc) please indicate a specialist consulted:_____
- ☐ Has been evaluated and treated for other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency, folate deficiency, etc)
- ☐ One of the following:
  - ☐ Has serum ferritin ≥ 100mcg/L and serum transferrin saturation ≥ 20%:_____
  - ☐ Is receiving supplemental iron therapy:_____
- ☐ For a diagnosis of anemia associated with chronic kidney disease, has pretretment hemoglobin <10g/dL
- ☐ For a diagnosis of anemia in cancer patients on chemotherapy, both of the following:
  - ☐ Has pretreatment hemoglobin <10g/dL
  - ☐ Is currently receiving myelosuppressive chemotherapy and the anticipated outcome is not cure
- ☐ For a diagnosis of anemia due to zidovudine in members with HIV infection, all of the following:
  - ☐ Has pretreatment hemoglobin <10g/dL
  - ☐ Has a serum erythropoietin level ≤500mUnits/mL
  - ☐ Is receiving a dose of zidovudine ≤4200mg/week
- ☐ For a reduction of allogeneic blood transfusion in surgery patients, both of the following:
  - ☐ Has pretreatment hemoglobin >10g/dL to ≤13g/dL

- ☐ Is undergoing elective, noncardiac, nonvascular surgery

RENEWAL REQUIEST:

- ☐ One of the following:
  - ☐ Experienced an increase in hemoglobin compared to baseline
  - ☐ Is prescribed an increased dose of the requested Erythropoiesis Stimulating Agents (ESA) consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- ☐ One of the following:
  - ☐ Has serum ferritin ≥ 100mcg/L and serum transferrin saturation ≥ 20%
  - ☐ Is receiving supplemental iron therapy
- ☐ For a diagnosis of anemia associated with chronic renal disease, has one of the following:
  - ☐ Hemoglobin ≤ 10g/dL for members not on dialysis
  - ☐ Hemoglobin ≤ 11g/dL for members on dialysis
- ☐ For a diagnosis of anemia in cancer patients on chemotherapy, has hemoglobin ≤ 12g/dL
- ☐ For a diagnosis of anemia due to zidovudine in members with HIV infection, all of the following:
  - ☐ Has pretreatment hemoglobin <12g/dL
  - ☐ Has a serum erythropoietin level ≤500mUnits/mL
  - ☐ Is receiving a dose of zidovudine ≤4200mg/week

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

PA Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)