



# 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 DOCUMENTATION (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?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Requests for all non-preferred Erythropoiesis Stimulating Agents:</b> Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Erythropoiesis Stimulating Agents? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred medications in this class.		<input type="checkbox"/> Yes Medication Taken Previously (start and end date and dose): _____ <input type="checkbox"/> No _____	
<input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to <a href="https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx">https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx</a> ), please provide supporting information: _____			
SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.			
INITIAL REQUEST:			
<input type="checkbox"/> If not prescribed by the following specialist, (e.g., hematologist/oncologist, gastroenterologist, infectious disease specialist, nephrologist, surgeon, etc) please indicate a specialist consulted: _____			
<input type="checkbox"/> Has been evaluated and treated for other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency, folate deficiency, etc)			
<input type="checkbox"/> One of the following: <input type="checkbox"/> Has serum ferritin $\geq 100\text{mcg/L}$ and serum transferrin saturation $\geq 20\%$ : _____ <input type="checkbox"/> Is receiving supplemental iron therapy: _____			
<input type="checkbox"/> For a diagnosis of anemia associated with chronic kidney disease, has pretreatment hemoglobin $<10\text{g/dL}$			
<input type="checkbox"/> For a diagnosis of anemia in cancer patients on chemotherapy, both of the following: <input type="checkbox"/> Has pretreatment hemoglobin $<10\text{g/dL}$ <input type="checkbox"/> Is currently receiving myelosuppressive chemotherapy and the anticipated outcome is not cure			
<input type="checkbox"/> For a diagnosis of anemia due to zidovudine in members with HIV infection, all of the following: <input type="checkbox"/> Has pretreatment hemoglobin $<10\text{g/dL}$ <input type="checkbox"/> Has a serum erythropoietin level $\leq 500\text{mUnits/mL}$ <input type="checkbox"/> Is receiving a dose of zidovudine $\leq 4200\text{mg/week}$			
<input type="checkbox"/> For a reduction of allogeneic blood transfusion in surgery patients, both of the following: <input type="checkbox"/> Has pretreatment hemoglobin $>10\text{g/dL}$ to $\leq 13\text{g/dL}$			

- ☐ Is undergoing elective, noncardiac, nonvascular surgery

**RENEWAL REQUEST:**

- ☐ 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  $\geq 100\text{mcg/L}$  and serum transferrin saturation  $\geq 20\%$
  - ☐ Is receiving supplemental iron therapy
- ☐ For a diagnosis of anemia associated with chronic renal disease, has one of the following:
- ☐ Hemoglobin  $\leq 10\text{g/dL}$  for members not on dialysis
  - ☐ Hemoglobin  $\leq 11\text{g/dL}$  for members on dialysis
- ☐ For a diagnosis of anemia in cancer patients on chemotherapy, has hemoglobin  $\leq 12\text{g/dL}$
- ☐ For a diagnosis of anemia due to zidovudine in members with HIV infection, all of the following:
- ☐ Has pretreatment hemoglobin  $<12\text{g/dL}$
  - ☐ Has a serum erythropoietin level  $\leq 500\text{mUnits/mL}$
  - ☐ Is receiving a dose of zidovudine  $\leq 4200\text{mg/week}$

**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.)