Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

ERYTHROPOIESIS STIMULATING AGENTS (ESAs)
Prior Authorization Form
ARANESP, EPOGEN, OMONTYS, & PROCRIT

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

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

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Diagnosis:	Date Diagnosed:

□ Anemia due to renal failure	If Yes, please complete the following: □ Acute □ Chronic
□ Anemia due to End Stage Renal Disease (ESRD)	Indicate severity of renal failure:_____
□ Non-myeloid Malignancy	Is member on renal dialysis: □ Yes □ No
□ Anemia due to chemotherapy	Anemia due to iron or folate deficiency? □ Yes □ No Due to Hemolysis? □ Yes □ No Due to GI bleed? □ Yes □ No

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

☐ HIV positive	Is the patient receiving Zidovudine? ☐ Yes ☐ No
☐ Anemia due to other cause	If Yes, please submit chart documentation indicating rationale for therapy and supportive lab values.

Does member have uncontrolled Hypertension? ☐ Yes ☐ No

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:_____

Is patient currently receiving iron supplement therapy?	☐ Yes ☐ No	Specify serum ferritin (mcg/L): ☐ <100 ☐ 100-200 ☐ >200 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				