reliance|rx℠
15 Earhart Drive, Suite 110, Amherst, NY 14221

# ERYTHROPOIETIN AUTHORIZATION AND REAUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

| | | | |
|---|---|---|---|
| Member Name: | Today's Date: | Date Needed: | |
| Date of birth: Sex: Weight: | | Prescriber: | Hospital/Clinic: |
| Home Phone Number: ( ) | | Phone Number: ( ) | Fax Number: ( ) |
| Home Address: | City: State: Zip: | Address: | City: State: Zip: |
| Payor: ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self-funded<br>Insurance ID: Group Number: | | Prescriber specialty: | |
| Will patient be self-administering medication? ☐ Yes ☐ No | | Allergies: | |

## STATEMENT OF MEDICAL NECESSITY

**Primary Diagnosis**: _____

**ICD10 Code** _____

****Please provide clinical office notes to support this request****

**IS EPOETIN ALPHA BEING ADMINISTERED FOR THE TREATMENT OF:**

1. Symptomatic anemia associated with chronic renal failure including patients on dialysis (End Stage Renal Disease) and not on dialysis? ☐ Yes ☐No

**OR:**

2. Chronic Kidney disease defined as GFR between 30-75mL/min/1.73m$^2$? ☐ Yes ☐No

   Provide GFR:_____

   - Non-Dialysis patient's hemoglobin is less than 10g/dL? ☐ Yes ☐No
   - Rate of hemoglobin decline indicated the likelihood of requiring a red blood cell transfusion? ☐ Yes ☐No
   - Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal? ☐ Yes ☐No

   **OR:**

   - Dialysis patient's hemoglobin is less than 10g/dL? ☐ Yes ☐No

**OR:**

3. Symptomatic anemia associated with zidovudine treated HIV infected patients when endogenous serum erythropoietin level is ≤ 500 mUnits/ml and patient is receiving a dose of zidovudine ≤ 4200mg/wk? ☐ Yes ☐No

   - Patient's hemoglobin is less than 11g/dL? ☐ Yes ☐No

**OR:**

4. Symptomatic anemia in a patient with a solid tumor, multiple myeloma, lymphoma or lymphocytic leukemia where anemia is due to the effect of concomitantly administered myelosuppressive chemotherapy? ☐ Yes ☐No

   - Anticipated duration of myelosuppressive chemotherapy:_____
   - Provider must enroll in and comply with ESA APRISE Oncology Program.
   - Patient's hgb is less than 10g/dL (or HCT less than 30%)? ☐ Yes ☐No

## DRUG SELECTION

☐ EPOGEN ☐PROCRIT ☐ RETACRIT

☐ New Authorization ☐ Re-authorization*

Dose: _____
Frequency: _____

Expected duration of therapy: _____

**OR:**

5. Is patient anemic and scheduled to undergo elective, noncardiac, nonvascular surgery to reduce the need for allogenic blood transfusion? ☐ Yes ☐No
6. If not being requested for any of the above indications, please provide the diagnosis for use and clinical rationale to support this request.

**FOR EPOGEN AND PROCRIT ONLY:**

Has Patient tried and failed or have a contraindication to Retacrit? ☐ Yes ☐No

HCT: _____ Date: _____

Hgb: _____ Date: _____

Ferritin Level: _____ Date: _____

Transferrin Saturation: _____ Date: _____

Most recent Blood Pressure reading: _____ Date: _____

**FOR RE-AUTHORIZATION:**

**Please submit lab work or office notes providing the following information**

HCT: _____ Date: _____

Hgb: _____ Date: _____

Ferritin Level: _____ Date: _____

Transferrin Saturation: _____ Date: _____

Most recent Blood Pressure reading: _____ Date: _____