MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

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

□ Standard Request (72 hours)
□ Expedited Request (24 hours)

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

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:

Hgb level (g/dL):_____ Date of test:_____

□ Anemia due to chronic kidney disease	Is member on renal dialysis?	□ Yes □ No
□ Non-myeloid malignancy on chemotherapy	Does member have at least 2 more months of planned chemotherapy?	□ Yes □ No
□ Reduction of risk for allogenic blood transfusions (Epogen and Procrit)	Is patient at high risk for perioperative transfusion?	□ Yes □ No
	Is patient scheduled to undergo elective, non-cardiac or nonvascular surgery?	□ Yes □ No
□ Ribavirin-induced anemia (Epogen and Procrit)	Was the dose of ribavirin reduced to see if symptoms of anemia resolved?	□ 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
Has iron status been evaluated and will continue to be evaluated during therapy?	☐ Yes ☐ No
What is the medication's starting dose?	What is the medication's maintenance dose:

Please provide any additional information which should be considered in the space below: