



Procrit
(epoetin alfa)
Prior Authorization Form

Express Scripts
Phone 800-417-8164
Fax 877-837-5922

Last Name		First Name		Prescriber's Name		Specialty			
Home Phone		Work Phone		Office Phone		Office Fax			
Home Address		City	State	ZIP	Address		City	State	ZIP
SCAN ID number				Date of Birth		Est. Start Date		Office Contact	
For Specialty Medications Only: Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home					Special Instructions (i.e. Non-English Speaking Patient, etc.):				

Medication:			Diagnosis:		
Sig:		Qty:	Refills:		ICD 9 Code:

Secondary/ Supplemental Insurance Company Number	Phone	Name of Insured	ID Number	Group
--	-------	-----------------	-----------	-------

1. Is the diagnosis or indication for the treatment of anemia associated with chronic kidney disease? If no continue to #8
2. Is the patient on dialysis?
3. Does the patient have a creatinine of 2.0 or greater or the creatinine clearance by any standard method is less than 45ml/min?
4. Is the patient iron deficient and not currently being treated for this deficiency?
5. Is the patient's current (or pre-transfusion) hemoglobin level <10g/dl?
6. Is this a diabetic patient with a symptomatic anemia?
7. Is the patient's target hemoglobin level within the range of 10 to 12 g/dl?
8. Is the diagnosis or indication for the reduction of allogeneic blood transfusion in patients with non-myeloid malignancies receiving concomitant myelosuppressive chemotherapy? If no continue to #10
9. Is the patient's current hemoglobin level ≥ 10g/dl?
10. Is the diagnosis or indication for the elevation or maintenance of red blood cell level and the reduction of allogeneic blood transfusion in anemic patients scheduled to undergo noncardiac, nonvascular surgery? If no continue to #12

11. Is antithrombotic prophylaxis considered?
12. Is the diagnosis or indication for the elevation or maintenance of red blood cell levels and the reduction of allogeneic blood transfusion in the anemia related to zidovudine-treatment in HIV-infected patients? If no continue to #14
13. Is the pretreatment endogenous serum erythropoietin level ≤ 500 micro units/ml?
14. Is the diagnosis or indication for the treatment of anemia in low or intermediate-1 risk Myelodysplastic Syndrome (MDS) patients?
15. Is the patient transfusion-dependent? If no continue to #16
16. Is the patient symptomatic from anemia, documented by such impairments as moderate to severe exercise intolerance, inability to perform activities of daily living, tachycardia, or shortness of breath with minimal activities?
17. Are there any other comments, diagnoses, symptoms, and/or any other information you feel is important to this review?

Physician's Signature: _____ NPI/DEA #: _____ Date: _____

<u>For Internal Use Only</u> <input type="checkbox"/> Approved <input type="checkbox"/> Denied Reviewer's Initials _____ Decision Date _____ Comments _____

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.