



Procrit
(epoetin alfa)

Prior Authorization Form
Curascript
Fax (888) 773-7386

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	Phone	Name of Insured	ID Number	Group Number
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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. What are the patient's serum creatinine level, creatinine clearance, and weight?

Is the patient iron deficient and not currently being treated for this deficiency?

Is the patient's current 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 #11
9. Is the anticipated outcome of myelosuppressive chemotherapy cure?
10. Is the patient's current hemoglobin level ≥ 10g/dl?
11. 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 #13
12. Is antithrombotic prophylaxis considered?
13. 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?
14. Is the pretreatment endogenous serum erythropoietin level ≤500 micro units/ml?
15. 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: _____

For Internal Use Only

Approved

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>.