SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Erythropoiesis Stimulating Agents (ESAs) *For Non-Dialysis Use*

This form is to be completed ONLY if the patient is self-administering

Drug Requested: (check one below)

❑ **Aranesp®** (darbepoetin alfa)	❑ **Epogen®** (epoetin alfa)	❑ **Mircera®** (methoxy polyethylene glycol-epoetin beta)
❑ **Procrit®** (epoetin alfa)	❑ **Retacrit™** (epoetin alfa-epbx)	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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❑ Diagnosis: Anemia Due to Chronic Kidney Disease

Initial Authorization: 6 months

- ❑ Member has a documented diagnosis of anemia due to chronic kidney disease (CKD)
- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member must meet **ONE** of the following hemoglobin requirements:
    - ❑ Member is an adult with a hemoglobin level <10 g/dL
    - ❑ Member is a pediatric patient who is symptomatic with a hemoglobin level <11 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%
- ❑ Member is **NOT** receiving hemodialysis
- ❑ All other causes of anemia have been ruled out (e.g., iron, vitamin B12 or folate deficiency, hemolysis)

❑ Diagnosis: Anemia Due to Chronic Kidney Disease

Reauthorization: 6 months. Check below all that apply. All criteria must be checked for approval. To support each line checked, all documentation, including (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member's hemoglobin level ≤ 12 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%

❑ Diagnosis: Anemia Due to Myelosuppressive Chemotherapy

Length of Authorization: 6 months

- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member must meet **ONE** of the following hemoglobin requirements:
    - ❑ Member is an adult with a hemoglobin level <10 g/dL
    - ❑ Member is a pediatric patient who is symptomatic with a hemoglobin level <11 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%
- ❑ Member is being treated with myelosuppressive chemotherapy and provider has noted member's current treatment regimen: _____
- ❑ All other causes of anemia have been ruled out (e.g., iron, vitamin B12 or folate deficiency, hemolysis)

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❑ **Diagnosis: Anemia Due to Myelodysplastic Syndrome (MDS)**

Initial Authorization: 6 months

- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member's hemoglobin level <10 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%
  - ❑ Member's serum erythropoietin level ≤ 500 milliunits/mL
- ❑ All other causes of anemia have been ruled out (e.g., iron, vitamin B12 or folate deficiency, hemolysis)

❑ **Diagnosis: Anemia Due to Myelodysplastic Syndrome (MDS)**

Reauthorization: 12 months. Check below all that apply. All criteria must be checked for approval. To support each line checked, all documentation, including (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member's hemoglobin level <12 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%
  - ❑ Member's serum erythropoietin level ≤ 500 milliunits/mL

❑ **Diagnosis: Anemia of Prematurity**

Length of Authorization: 6 months

- ❑ Documentation of **ALL** the following must be submitted:
  - ❑ Medication will be used in combination with iron supplementation
  - ❑ Member must meet **ONE** of the following:
    - ❑ Member's birth weight <1500 grams
    - ❑ Member's gestational age <33 weeks

❑ **Diagnosis: Anemia Due to Myelosuppressive Medication Regimen for HIV**

Initial Authorization: 6 months

- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member must meet **ONE** of the following hemoglobin requirements:
    - ❑ Member is an adult with a hemoglobin level <10 g/dL
    - ❑ Member is a pediatric patient who is symptomatic with a hemoglobin level <11 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)

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- ❑ Member's transferrin saturation (TSAT) ≥ 20%
- ❑ Member's serum erythropoietin level ≤ 500 milliunits/mL

❑ Member is being treated with an HIV medication regimen that includes zidovudine (≤ 4200mg/week)

❑ All other causes of anemia have been ruled out (e.g., iron, vitamin B12 or folate deficiency, hemolysis)

❑ Diagnosis: Anemia Due to Myelosuppressive Medication Regimen for HIV

Reauthorization: 6 months. Check below all that apply. All criteria must be checked for approval. To support each line checked, all documentation, including (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

❑ Member continues to receive an HIV medication regimen that includes zidovudine (≤ 4200 mg/week)

❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:

- ❑ Member's hemoglobin level ≤12 g/dL
- ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
- ❑ Member's transferrin saturation (TSAT) ≥ 20%
- ❑ Member's serum erythropoietin level ≤ 500 milliunits/mL

❑ Diagnosis: Anemia Due to Myelosuppressive Medication Regimen for Hepatitis C

Initial Authorization: 6 months

❑ Member has a documented diagnosis of anemia

❑ Member is being treated with a myelosuppressive regimen (e.g., ribavirin with interferon or peginterferon) for the treatment of Hepatitis C

❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:

- ❑ Member must meet **ONE** of the following hemoglobin requirements:
  - ❑ Member is an adult with a hemoglobin level <10 g/dL
  - ❑ Member is a pediatric patient who is symptomatic with a hemoglobin level <11 g/dL
- ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
- ❑ Member's transferrin saturation (TSAT) ≥ 20%

❑ All other causes of anemia have been ruled out (e.g., iron, vitamin B12 or folate deficiency, hemolysis)

❑ Diagnosis: Anemia Due to Myelosuppressive Medication Regimen for Hepatitis C

Reauthorization: 6 months. Check below all that apply. All criteria must be checked for approval. To support each line checked, all documentation, including (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

❑ Member continues to receive a myelosuppressive regimen for the treatment of Hepatitis C

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- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member's hemoglobin level ≤12 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%

❑ Diagnosis: Reduction of Allogenic Red Blood Cell Transfusions in Patients Undergoing Elective, Noncardiac, Nonvascular Surgery

Length of Authorization: 3 months

- ❑ Requested drug will be used to decrease the need for blood transfusion in a surgery patient
- ❑ Member is scheduled to undergo surgery within the next three (3) months
- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member's hemoglobin level <13 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%
- ❑ All other causes of anemia have been ruled out (e.g., iron, vitamin B12 or folate deficiency, hemolysis)

❑ Diagnosis: All Other Indications

Length of Authorization: 6 months

- ❑ Member's diagnosis of anemia and/or risk factors for development of anemia must be noted in submitted chart notes for medical necessity approval
- ❑ Provider must document requested length of therapy: _____
- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member's current hemoglobin level: _____
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%
  - ❑ If applicable, any other test results to support medical necessity approval
- ❑ All other causes of anemia have been ruled out (e.g., iron, vitamin B12 or folate deficiency, hemolysis)

Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*