

**Neighborhood Health Plan of Rhode Island
Prior authorization Form**

Chemotherapy Induced Anemia

Epogen®/Procrit® (epoetin alpha)

Customer Service (401)-459-6020, Fax (866)-423-0945

Due to safety concerns, Neighborhood has implemented guidelines for ESA coverage, taking into consideration the clinical criteria established by CMS/ASH National Coverage Determination (NCD) and the expertise of local oncologists. Documentation of a Hb level ≤ 10 g/dL is required for initial coverage of ESA for chemotherapy induced anemia. **Verification that Hb levels remain < 12 g/dL will be required every 4 weeks.** As with CMS guidelines, off-label indications will not be covered by NHPRI.

Member Name (required) _____	Member ID Number: (required) <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>								
Member Date of Birth: (required) / /									
Prescriber Name: (required) _____	Contact Person at Office: _____								
Office Phone number: (required) () -	Office Fax Number: (required) () -								

Prescriber Specialty: (Circle one) Hematologist Oncologist Nephrologist Other _____

Please CHECK the appropriate boxes and fill out the following information:

DIAGNOSIS

- Pt is diagnosed with anemia secondary to myelosuppressive anticancer chemotherapy for solid tumors, multiple myeloma, lymphoma, OR lymphocytic leukemia and will start, or is currently undergoing, chemotherapy
- Patient is receiving post-chemotherapy treatment requested (within 8 weeks of stop date). Chemotherapy completed on (date) _____.

TREATMENT

Initial Therapy:

- Hb is ≤ 10 g/dL Hb level _____ Date labs drawn _____

Ongoing Maintenance Treatment:

- Hb is ≤ 12 g/dL and has not risen > 1 g/dL in last 2 weeks Hb level _____ Date labs drawn _____

ESA may not be administered to patients to target a hemoglobin level of greater than 12 g/dL due to increased risk of death and cardiovascular events.

If approval criteria are met, Neighborhood will authorize coverage of Epogen ®/Procrit® . **Failure to provide dates/values of lab tests will result in NHPRI not paying for the ordered drug, and may delay delivery of the drug to patient.**

Initial approval will be for 4 weeks at which time patient should be evaluated for response to therapy. If patient is responding to therapy and continues to meet criteria, monthly approvals will be granted

Medication Directions _____

PRESCRIBER SIGNATURE _____ NPI _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.