State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
ERYTHROPOIETIN (EPO)

Phone: 1-888-445-0497 **ONE Drug Per Form ONLY – Use Black or Blue Ink** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

Patient Address:_____

Provider DEA: |__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:_____ Phone:_____

Provider Address:_____ Fax:_____

Pharmacy Name:_____Rx Address:_____Rx phone:_____

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

Important Limitation of Use: Erythropoiesis Stimulating Proteins have not been shown to improve quality of life, fatigue, or patient well-being.

Drug (Step Order)	Strength	Dosage Instructions	Quantity	Days Supply (34 retail / 90 mail order)	Circle Refills
❑ PROCRIT® (5)	_____	_____	_____	_____	1 2 3 4 5
❑ EPOGEN® (6)	_____	_____	_____	_____	1 2 3 4 5
❑ ARANESP® (8)	_____	_____	_____	_____	1 2 3 4 5

Medical Necessity Documentation

Diagnosis:

- ❑ Anemia due to CKD (non-dialysis)
- ❑ Anemia due to CKD on dialysis
- ❑ Anemia due to Zidovudine HIV therapy
- ❑ Anemia due to cancer chemotherapy
- ❑ Reduction of allogenic RBC transfusions when undergoing surgery
- ❑ Other (describe) _____

Requirements (***Note: All lab tests must be dated within the last 30 days if stable. When initiating/adjusting therapy, monitor hemoglobin levels weekly. Please attach all lab results***)

☐ Does the EPO user have uncontrolled hypertension? If no, continue to next question.

☐ Will transferrin saturation and serum ferritin levels be evaluated prior to and during treatment? (please attach lab results) Is yes, continue to next question.

☐ Will iron therapy be given if serum ferritin is <100mcg/L or serum transferrin saturation is <20% or is member currently on therapeutic iron? If currently on iron, what is the name/strength?

☐ Cases of pure red cell aplasia and of severe anemia have been reported with use. If severe anemia and low reticulocyte count develops during treatment, will treatment be withheld and evaluation of patient be done? If yes, continue below to specific indication for use.

☐ **CKD non-dialysis diagnosis:**

☐ Is hemoglobin <10g/dL AND the rate of hemoglobin decline indicates the likelihood of requiring a RBC transfusion AND reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal?

☐ Will treatment be reduced or the dose be interrupted if hemoglobin levels exceed 10g/dL?

☐ Will the lowest dose be used to maintain a hemoglobin level that will reduce the need for a BRC transfusion?

☐ If an established user, please submit current and initial hemoglobin level, in addition of documentation showing attempts to titrate dose downwards.

☐ **CKD dialysis diagnosis:**

☐ Is hemoglobin <10g/dL?
☐ Will treatment be reduced or the dose be interrupted if hemoglobin levels approach or exceed 11g/dl?
☐ Will the lowest dose be used to maintain a hemoglobin level that will reduce the need for a BRC transfusion?
☐ If an established user, please submit current and initial hemoglobin level, in addition of documentation showing attempts to titrate dose downwards.

☐ **Cancer chemotherapy diagnosis:**

☐ Is the prescriber enrolled in the ESA APRISE Oncology Program?
☐ Is the hemoglobin <10g/dL AND a minimum of two additional months of planned chemotherapy?
☐ Will the lowest dose of treatment be used to maintain a hemoglobin level to avoid RBC transfusion?
☐ If an established user, please submit current and initial hemoglobin level, in addition of documentation showing attempts to titrate dose downwards.
☐ Will treatment be discontinued if after 8 weeks there is no response as measured by hemoglobin levels or if RBC transfusions are still needed?

☐ **Zidovudine HIV treatment diagnosis (Epogen®/Procrit® only):**

☐ Are endogenous serum erythropoietin levels of ≤500mU/ml?
☐ Will treatment be withheld if hemoglobin exceeds 12g/dL?
☐ When hemoglobin declines to <11g/dL, will the dose of therapy be reduced to 25% below the previous dose?
☐ Will treatment be discontinued if an increase in hemoglobin is not achieved at a dose of 300U/kg for 8 weeks?

☐ **Reduction of Allogenic RBC transfusion when undergoing surgery (Epgoen®/Procrit® only):**

☐ Is the perioperative hemoglobin >10 to ≤13g/dL?
☐ Is the user at high risk for perioperative blood loss from elective, non-cardiac, or non-vascular surgery?
☐ Will DVT prophylaxis be used during EPO treatment? If yes, list name/strength.

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ Date of Submission: _____
***MUST MATCH PROVIDER LISTED ABOVE**