BlueCross BlueShield Federal Employee Program®

EPOETIN ALFA
PRIOR APPROVAL REQUEST

Send completed form to:
FAX: 855-895-3504
FOR URGENT FAX: 844-244-0226

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

For Standard Option patients Retacrit is a preferred product. Please consider prescribing the preferred product.
Standard Option patients who switch to a preferred product can receive up to 2 fills without a copay in the benefit year.

NOTE: Form must be completed in its **entirety** for processing

Please select medication: ❑**Epogen (epoetin alfa)** ❑**Procrit (epoetin alfa)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Note: Approval cannot be given unless all lab values are provided for the diagnosis chosen

Is this request for brand or generic? ❑Brand ❑Generic

Procrit Request (Standard Option): Would you like to switch the patient to the preferred product, Retacrit? ❑Yes ❑No*

If NO,** does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Retacrit? ***Please select answer below:

❑**Yes** ***(please specify)***: _____

❑**No**: Is there a clinical reason for not trying Retacrit? ❑Yes* ❑No

If YES, please specify: _____

1. Is this medication being used in combination with another erythropoiesis stimulating agent (ESA)? ❑Yes* ❑No

   If YES, please specify the medication: _____

2. What is the patient's diagnosis?

   ❑Allogeneic bone marrow transplantation
   ❑Anemia associated with Hepatitis C (HCV) treatment
   ❑Myelodysplastic syndrome
   ❑Anemia associated with Rheumatoid Arthritis (RA)/rheumatic disease
   ❑Anemia associated with chronic renal failure

   a. What is the patient's serum ferritin level in nanograms per milliliter (ng/mL)? _____ ng/mL

   b. Have both the serum ferritin level and hemoglobin level been obtained within the past three months? ❑Yes ❑No

   c. Has the patient been on this medication continuously for the last **4 months**, excluding samples? ***Select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

   i. Is the patient on dialysis? ***Please select answer below:***

   ❑**Yes**: What is the patient's *hemoglobin level in grams per deciliter (g/dL)? _____ g/dL

   ***If hemoglobin level is greater than or equal to 10g/dL**, will the dose be held or reduced until the hemoglobin level is less than 10 grams per deciliter (g/dL)? ❑Yes ❑No

   ❑**No**: What is the patient's *hemoglobin level in grams per deciliter (g/dL)? _____ g/dL

   ***If hemoglobin level is greater than or equal to 11g/dL**, will the dose be held or reduced until the hemoglobin level is less than 11 grams per deciliter (g/dL)? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question(s):

   i. What is the patient's *hemoglobin level in grams per deciliter (g/dL)? _____ g/dL

   ***If hemoglobin level is greater than 11g/dL**, will the dose be held or reduced until the hemoglobin level is less than or equal to 11 grams per deciliter (g/dL)? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑Anemia in patients scheduled to undergo elective, non-cardiac, nonvascular surgery

a. What is the patient's hemoglobin level in grams per deciliter (g/dL)? _____ g/dL

❑Anemia secondary to chemotherapy

a. Is the patient receiving concomitant myelosuppresive therapy? ❑Yes ❑No

b. Are there 2 or more additional months of chemotherapy planned for the patient? ❑Yes ❑No

c. Will the prescriber agree to discontinue use of this medication upon completion of the chemotherapy? ❑Yes ❑No

d. Does the prescriber agree that transfusions are **NOT** an option for treatment (i.e., end stage organ failure, chronic kidney disease (CKD), and high risk bacterial infections)? ❑Yes ❑No

❑Anemia secondary to zidovudine-treated Human Immunodeficiency Virus (HIV) patients

a. Are the patient's endogenous serum erythropoietin levels less than or equal to 500 milliunits per milliliter (mU/mL)? ❑Yes ❑No

❑Other diagnosis ***(please specify):*** _____