Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Epogen – Procrit - Retacrit (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Epogen – Procrit - Retacrit (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name ***(circle drug)***

Epogen (epoetin alfa) Procrit (epoetin alfa) Retacrit (epoetin alfa-epbx)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____
Member ID: _____
Member Group No.: _____
Member DOB: _____
Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 3.]

2. Does the member meet both of the following conditions for approval: A) hemoglobin less than 11 g/dL within the last 2 weeks, and B) member has had follow up iron studies showing adequate iron stores to support erythropoiesis (e.g., serum ferritin at least 100ng/mL, transferrin saturation at least 20 percent)? Y N

   Document hemoglobin and results of iron studies including date drawn:
   _____

[No further questions.]

3. Does the member have adequate iron stores to support erythropoiesis as evidenced by one of the following: A) serum ferritin greater than or equal to 100 ng/ml and transferrin saturation (iron saturation) greater than or equal to 20 percent, or B) reticulocyte hemoglobin content (CHr) greater than 29 pg? Y N

   Document Iron Studies obtained, results, and date drawn: _____

   [If no, then no further questions.]

4. Does the member have uncontrolled hypertension (high blood pressure)? Y N

   [If yes, then no further questions.]

5. Does the member have a diagnosis of anemia due to chronic kidney disease? Y N

   [If no, skip to question 7.]

6. Does the member have hemoglobin less than 10 g/dL within 2 weeks prior to initiating therapy? Y N

   Document hemoglobin and date drawn: _____

   [If yes, skip to question 18.] [If no, then no further questions.]

7. Is therapy requested for the treatment of anemia in a cancer member? Y N

   [If no, skip to question 10.]

8. Is the member currently receiving myelosuppressive chemotherapy? Y N

   [If no, then no further questions.]

9. Does the member meet all of the following conditions for approval: A) hemoglobin less than 10 g/dL within the 2 weeks prior to starting therapy, B) diagnosis of non-myeloid malignancy (for example, solid tumor), and C) member will receive chemotherapy for at least 2 additional months? Y N

   Document hemoglobin and date drawn: _____

   [If yes, go to question 18.] [If no, then no further question]

10. Is the request for a member with high risk factors for bleeding who will be undergoing elective, noncardiac, and nonvascular surgery? Y N

    [If no, skip to question 14.]

11. Does the member have a hemoglobin level greater than 10 but less than or equal to 13 g/dL within 30 days prior to the planned surgery date? Y N

Document hemoglobin and date drawn: _____

[If no, then no further questions.]

12. Is this request for Procrit? Y N

[If no, then no further questions.]

13. Has the member experienced treatment failure or intolerable side effects with both of the following: A) Epogen and B) Retacrit? Y N

[No further questions.]

14. Is therapy requested for the treatment of anemia in a member with human immunodeficiency virus (HIV) who is taking zidovudine? Y N

[If no, skip to question 16.]

15. Is the zidovudine dose less than or equal to 4200 mg/week? Y N

[If yes, skip to question 17.] [If no, then no further questions.]

16. Is therapy requested for the treatment of anemia associated with myelodysplastic syndrome (MDS)? Y N

[If no, then no further questions.]

17. Does the member meet all of the following conditions for approval: A) hemoglobin is less than 10 g/dL within 2 weeks prior to initiating therapy, and B) endogenous erythropoietin level is less than or equal to 500 IU/L? Y N

Document erythropoietin and hemoglobin levels and dates drawn:
_____

[If no, then no further questions.]

18. Is this request for Procrit? Y N

[If no, then no further questions.]

19. Has the member experienced treatment failure or intolerable side effects with both of the following: A) Epogen and B) Retacrit? Y N

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature **Date**