

Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

ANAGRELIDE

Coverage Criteria / Required Medical Information

Prescriber must be Hematologist or Oncologist.

A. Chronic Myelogenous Leukemia:

- a. persistent granulocyte count $\geq 50,000/\text{mcL}$ without infection
- b. absolute basophil count $\geq 100/\text{mcL}$
- c. evidence of hyperplasia of the granulocytic line in the bone marrow
- d. presence of the Philadelphia chromosome
- e. leukocyte alkaline phosphatase \leq lower limit of the lab range.

B. Polycythemia Vera (either all three major criteria or first two major criteria and two minor criteria):

major criteria: increased red cell mass (in men, $\geq 36 \text{ mL/kg}$ and in women, $\geq 32 \text{ mL/kg}$); normal arterial oxygen saturation ($\geq 92\%$); splenomegaly.

minor criteria: platelet count $\geq 400,000/\text{mcL}$ without iron deficiency or bleeding;
white blood cell count $\geq 12,000/\text{mcL}$ without infection; leukocyte alkaline phosphatase $\geq 100 \text{ mcL}$;
serum B12 $> 900 \text{ pcg/mL}$.

C. Thrombocytosis:

- a. platelet count $\geq 900,000/\text{mcL}$
- b. profound megakaryocytic hyperplasia in bone marrow
- c. absence of Philadelphia chromosome
- d. normal red cell mass
- e. normal serum iron and ferritin **and** normal marrow iron stores
- f. pre-treatment cardiovascular examination.

Coverage Duration: 6 months

Exclusion Criteria:

Severe hepatic impairment.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			



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Requested Drug			
ANAGRELIDE	Reason for Request		
Condition/Diagnosis Related			
Clinical Drug/Lab History Pertinent to Request			
Labs: Baseline/Ongoing		Strength/Dosage	
Formulary Alternative(s) Attempted?	Yes:		No: <input type="checkbox"/>
Please List Alternative Formulary Drugs			
Comments			

Physicians Signature: _____ Fax Form to 1-866-481-3704