

Sterling Retiree Rx Prior Authorization Form

PROCRIT (Epoetin alfa)

Coverage Criteria / Required Medical Information

All FDA approved indications not otherwise excluded from Part D.

Following labs performed within 30 days of request:

Hgb (≤ 10 g/dL for initial authorization; < 12 g/dL for re-authorization) **or**

Hct ($\leq 30\%$ for initial authorization; $< 36\%$ for re-authorization)

In addition, for **CKD**, transferrin saturation $\geq 20\%$ **and** ferritin level ≥ 100 ng/ml .

For **chemo-induced anemia**: Diagnosis is non-myeloid malignancy and patient is receiving concomitant myelosuppressive chemotherapy regimen without an anticipated outcome of cure **and** serum EPO level ≤ 200 mUnits/mL prior to therapy.

For **anemia secondary to MDS and in HIV-infected patients**: serum EPO level ≤ 500 mUnits/mL prior to therapy. In addition, **HIV-infected patient** must be on concurrent anti-retroviral therapy.

For **surgery patients** - require Hgb level > 10 g/dL but ≤ 13 g/dL **and** patient is at high risk for perioperative blood loss **and** must be receiving iron supplementation.

Re-authorization: increase in Hgb of at least 1 g/dL **or** Hct of at least 3% since the initial EPO treatment.

Exclusion Criteria

Uncontrolled hypertension; red cell aplasia;

Hgb greater than 12 g/dL (with the exception of surgery patients - Hgb greater than 13 g/dL).

Coverage Duration: 12 weeks

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		
PROCRIT	Reason for Request	
Condition/Diagnosis Related		
Clinical Drug/Lab History Pertinent to Request		
Labs: Baseline/Ongoing	Strength/Dosage	
Please List Alternative Formulary Drugs		
Comments		

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