



**PRIOR AUTHORIZATION FORM
Erythropoietin & Darbepoetin**

PROVIDER INFORMATION

NAME _____

NPI # _____

ADDRESS _____

PHONE # _____ FAX # _____

CONTACT NAME _____

PROVIDER SIGNATURE _____

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID # _____

BIRTHDATE _____

PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

Drug Requested: _____ **Dose/frequency:** _____

Diagnosis: _____ **ICD-9 code** _____

If *not* obtained at a pharmacy for self administration:

- Obtain at MVP's specialty pharmacy (CuraScript) for office administration (*may be required*)
- Office/Hospital/ Infusion Center: Place of Service _____
- Other _____

Initial Therapy Request

Indication (check appropriate box):

- end-stage renal disease w/o dialysis Serum creatinine _____ GFR _____
- chemotherapy-induced anemia
diagnosis and number of months on chemotherapy: _____
- MDS (include bone marrow biopsy results here): _____
- AZT-induced anemia (include AZT daily dose here): _____
- other (indicate diagnosis & ICD9, provide chart notes and laboratory reports): _____

Pertinent Lab Data

	Baseline HgB	Ferritin	Transferrin Sat.	Folate	B12	Most Recent HgB
Level						
Date						

Fecal occult blood test (circle one) Positive or Negative
 Uncontrolled hypertension (circle one) Yes or No
 Erythropoietin level (not required if dx is renal disease or chemo-induced anemia) _____
 Has this patient recently been transfused (circle one)? Yes No If yes, provide date: _____
 Confirm tests have been done to rule out other causes of anemia (underlying infections, hemolysis etc) Yes or No

Extension of Therapy Request

Number of transfusions in last 90 days. _____ units
 Current erythropoietin/darbepoetin dose/frequency _____
 Is this patient receiving iron (IV or PO) supplementation (circle one) Yes or No

Pertinent Lab Data

	Baseline HgB	Ferritin	Transferrin Sat.	Folate	B12	Most Recent HgB
Level						
Date						

If hematocrit > 30, provide chart notes to document medical necessity (ie: co-morbid conditions)

PLEASE NOTE: ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.

Refer to the MVP Formulary at www.mvphealthcare.com for those drugs that require prior authorization or are subject to quantity limits or step therapy.

FAX THIS REQUEST TO:

Commercial 1-800-376-6373
(HMO, EPO/PPO, Option, Healthy NY,
Personal Plan, CompCare, ASO)

Medicare Part D 1-800-401-0915
(Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)

Effective July 2011