{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

Please indicate patient's therapy status:

- ❑ New start or re-start of therapy
- ❑ Continuation of therapy
- ❑ Therapy is complete
- ❑ Therapy is on hold or patient has medication available

Please retain the following form for submission when therapy resumes or when supply of medication is low.

1. What is the patient's diagnosis?
   - ❑ Anemia due to chronic kidney disease (CKD)
   - ❑ Anemia due to myelosuppressive chemotherapy
   - ❑ Anemia in myelodysplastic syndrome (MDS)
   - ❑ Anemia in patients whose religious beliefs forbid blood transfusions
   - ❑ Anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis
   - ❑ Anemia due to cancer
   - ❑ Other_____
2. What is the ICD-10 code? _____
3. What is the patient's hemoglobin (Hgb) level? Exclude values due to recent transfusion.

   Pretreatment (i.e., within 30 days of request): Hgb: _____ g/dL Date of lab: _____

   Current (i.e., within 30 days of request): Hgb: _____ g/dL Date of lab: _____

   ❑ Unknown or lab not drawn
4. Will the requested medication be used concomitantly with other erythropoiesis stimulating agents (ESAs)?
   ❑ Yes ❑ No
5. Has the patient received erythropoiesis stimulating agent (ESA) therapy in the previous month (within 30 days of request)? ❑ Yes ❑ No *If No, skip to #7*
6. Has the patient completed at least 12 weeks of ESA therapy? *Indicate therapy start date and number of weeks completed. Start Date:* _____ *Number of weeks completed* _____

7. At any time since the patient started ESA therapy, has the patient's hemoglobin (Hgb) increased by 1 g/dL or more? ❑ Yes ❑ No
8. Has the patient been assessed for iron deficiency anemia? ❑ Yes ❑ No
9. What is the most recent serum transferrin saturation (TSAT) level? Indicate percentage.
   _____% ❑ Unknown *If Less than 20% or unknown skip to #11*
10. Was the most recent serum transferrin saturation (TSAT) level obtained within the prior 3 months? *Indicate date lab was drawn. If Yes, skip to diagnosis section.* ❑ Yes - _____ ❑ No
11. Is the patient receiving iron therapy? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Anemia Due to Myelosuppressive Chemotherapy

1. Does the patient have a non-myeloid malignancy? ❑ Yes ❑ No
2. What is the patient's current hemoglobin (Hgb) level (exclude values due to a recent transfusion)?
   ❑ Less than 12 g/dL
   ❑ Greater than or equal to 12 g/dL
   ❑ Unknown
3. Was the patient's current hemoglobin (Hgb) level drawn within 30 days of the request (exclude values due to a recent transfusion)? *Indicate date lab was drawn.* _____ ❑ Yes ❑ No ❑ Unknown
4. What is the patient's pretreatment serum erythropoietin (EPO) level?
   ❑ Less than 500 mU/mL
   ❑ Greater than or equal to 500 mU/mL
   ❑ Unknown

Section B: Anemia Due to Chronic Kidney Disease (CKD), Anemia in Patients Whose Religious Beliefs Forbid Blood Transfusions, Anemia in Myelodysplastic Syndrome (MDS), or Anemia in Primary Myelofibrosis, Post-Polycythemia Vera Myelofibrosis, or Post-Essential Thrombocythemia Myelofibrosis

1. What is the patient's current hemoglobin (Hgb) level (exclude values due to a recent transfusion)?
   ❑ Less than 12 g/dL
   ❑ Greater than or equal to 12 g/dL
   ❑ Unknown
2. *If diagnosis is Anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis,* what is the patient's pretreatment serum erythropoietin (EPO) level?
   ❑ Yes ❑ No ❑ NA - diagnosis is not for Anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis

Section C: Anemia Due to Cancer

1. Is the patient undergoing palliative treatment? ❑ Yes ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date