BlueCross BlueShield Federal Employee Program

EPOETIN ALFA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

For Standard Option patients Retacrit is a preferred product. Please consider prescribing the preferred product. Standard Option patients who switch to a preferred product can receive up to 2 fills without a copay in the benefit year.

NOTE: Form must be completed in its **entirety** for processing

Please select medication: ❑**Epogen (epoetin alfa)** ❑**Procrit (epoetin alfa)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Note: Approval cannot be given unless all lab values are provided for the diagnosis chosen

Is this request for brand or generic? ❑Brand ❑Generic

Procrit Request (Standard Option): Would you like to switch the patient to the preferred product, Retacrit? ❑Yes ❑No*

If NO,** does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Retacrit? ***Please select answer below:

❑**Yes** ***(please specify)***: _____

❑**No**: Is there a clinical reason for not trying Retacrit? ❑Yes* ❑No

***If YES**, please specify: _____

1. Is this medication being used in combination with another erythropoiesis stimulating agent (ESA)? ❑Yes* ❑No

   ***If YES**, please specify the medication: _____

2. What is the patient's diagnosis?

   ❑Allogeneic bone marrow transplantation
   ❑Anemia associated with Hepatitis C (HCV) treatment
   ❑Myelodysplastic syndrome
   ❑Anemia associated with Rheumatoid Arthritis (RA)/rheumatic disease
   ❑Anemia associated with chronic renal failure

   a. What is the patient's serum ferritin level in nanograms per milliliter (ng/mL)? _____ ng/mL

   b. Have both the serum ferritin level and hemoglobin level been obtained within the past three months? ❑Yes ❑No

   c. Has the patient been on this medication continuously for the last **4 months**, excluding samples? ***Select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

   i. Is the patient on dialysis? ***Please select answer below:***

   ❑**Yes**: What is the patient's *hemoglobin level in grams per deciliter (g/dL)? _____ g/dL

   ***If hemoglobin level is greater than or equal to 10g/dL**, will the dose be held or reduced until the hemoglobin level is less than 10 grams per deciliter (g/dL)? ❑Yes ❑No

   ❑**No**: What is the patient's *hemoglobin level in grams per deciliter (g/dL)? _____ g/dL

   ***If hemoglobin level is greater than or equal to 11g/dL**, will the dose be held or reduced until the hemoglobin level is less than 11 grams per deciliter (g/dL)? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question(s):

   i. What is the patient's *hemoglobin level in grams per deciliter (g/dL)? _____ g/dL

   ***If hemoglobin level is greater than 11g/dL**, will the dose be held or reduced until the hemoglobin level is less than or equal to 11 grams per deciliter (g/dL)? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Anemia in patients scheduled to undergo elective, non-cardiac, nonvascular surgery

a. What is the patient's hemoglobin level in grams per deciliter (g/dL)? _____ g/dL

❑Anemia secondary to chemotherapy

a. Is the patient receiving concomitant myelosuppresive therapy? ❑Yes ❑No

b. Are there 2 or more additional months of chemotherapy planned for the patient? ❑Yes ❑No

c. Will the prescriber agree to discontinue use of this medication upon completion of the chemotherapy? ❑Yes ❑No

d. Does the prescriber agree that transfusions are **NOT** an option for treatment (i.e., end stage organ failure, chronic kidney disease (CKD), and high risk bacterial infections)? ❑Yes ❑No

❑Anemia secondary to zidovudine-treated Human Immunodeficiency Virus (HIV) patients

a. Are the patient's endogenous serum erythropoietin levels less than or equal to 500 milliunits per milliliter (mU/mL)? ❑Yes ❑No

❑Other diagnosis ***(please specify):*** _____

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***