

**PRE-DETERMINATION REQUEST**

Procrit®, Epogen® (Epoetin alfa), Aranesp® (Darbepoietin alfa)

Complete form in its entirety and fax to:

PrecisionRx Specialty Solutions

FAX (866) 545-0062

**Anthem UM  
Services, Inc.****Part I: Patient Information**

|                        |                          |  |                      |                |                |
|------------------------|--------------------------|--|----------------------|----------------|----------------|
| Patient's Last Name    |                          | First Name   |                      | Middle Initial | I.D. no.       |
| Address                |                          | City   | County               |                | State Zip code |
| Day Phone no.<br>( ) - | Night Phone no.<br>( ) - | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth<br>/ / |                | Allergies      |
| Primary Insurance:     |                          |  | Cardholder ID:       |                | Group #:       |

**Part II: Prescriber Information**

|                                 |  |                               |        |   |                |
|---------------------------------|--|-------------------------------|--------|---|----------------|
| Prescriber's name               |  | Provider's license no.        |        | Office Contact Name and phone number or extension |                |
| Address                         |  | City                          | County |   | State Zip code |
| Phone no. (+area code)<br>( ) - |  | Fax no. (+area code)<br>( ) - |        | DEA no.   |                |

**Part III: Clinical Information****Diagnosis • ICD-9 Code:** \_\_\_\_\_

| Clinical Data  | Lab Data  |   |
|--|---|---|
| Patient Weight _____ lb / kg   | Hemoglobin (Hgb) (g/dL): _____  | *Ferritin (ng/mL): _____                  |
| Is the patient's blood pressure in good control?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Date of Test: ____/____/____  | *Transferrin Saturation (TSAT) (%): _____ |
|  | Bone Marrow with acceptable iron stores <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____ | Date of Test: ____/____/____              |

\*Note – Iron stores (Ferritin/TSAT) are always required at initial review. On re-authorization, submit re-evaluation of iron stores when the Hgb falls or remains below the suggested target range or provide documentation of acceptable iron stores on bone marrow analysis.

➤ Date of last dose of erythropoietin stimulating agent (ESA): \_\_\_\_/\_\_\_\_/\_\_\_\_ (check here if first dose ↑ )

**Initial Request (First dose or more than 3 months since last dose)**

|  |  |
|--|--|
| <input type="checkbox"/> Anemia due to Chronic Renal Failure / End Stage Renal Disease   | <input type="checkbox"/> Status post Allogeneic Bone Marrow Transplant   |
| <input type="checkbox"/> Anemia due to Cancer Chemotherapy planned to last at least two months for a non-myeloid cancer where the anticipated outcome of treatment is not cure.<br>• Type of malignancy: _____   | <input type="checkbox"/> Anemia due to Myelodysplastic Syndrome<br>• Erythropoietin (EPO) Level: _____ mU/mL   |
| <input type="checkbox"/> Anemia & Reduction of Allogeneic Blood Transfusion prior to surgery<br>• Anticipated Date of surgery ____/____/____<br>• Type of surgery: _____<br>• Has Antithrombotic prophylaxis been considered? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>• Is the surgery elective, noncardiac, nonvascular surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>• Is the patient at high risk for perioperative transfusions with significant blood loss? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>• Is the Patient unable, or unwilling to donate autologous blood? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Anemia due to Chemotherapy Treated Chronic Inflammatory disease<br>• Indicate the inflammatory condition: _____<br>• Indicate chemotherapy agent(s) _____<br><br><input type="checkbox"/> Anemia due to Zidovudine (AZT) therapy<br>• Daily dosage of Zidovudine? _____ mg<br>• Erythropoietin (EPO) Level: _____ mU/mL |
|  | <input type="checkbox"/> Anemia due to Hepatitis C therapy with interferon-alfa + ribavirin?   |

**Re-authorization (3 months or less since last dose)**

|  |
|--|
| <input type="checkbox"/> Hgb ≥ 10 g/dL and ≤ 12 g/dL <b>AND</b> dose maintained  |
| <input type="checkbox"/> Hgb has increased to > 12g/dL and < 13 g/dL <b>AND</b> ESA therapy has been temporarily stopped and restarted <b>OR</b> continued at a decreased dose |
| <input type="checkbox"/> Hgb has increased by < 1g/dL over 4 weeks of therapy <b>AND/OR</b> Hgb < 10g/dL <b>AND</b> dose has been increased <b>AND</b> Iron stores reassessed  |
| <input type="checkbox"/> Anemia due to chemotherapy, interferon/ribavirin, or zidovudine, and treatment of primary condition continues and/or was stopped < 8 weeks ago        |

**Part IV: MEDICATION ORDER**

|  |   |
|--|---|
| <input type="checkbox"/> Epogen® <input type="checkbox"/> Procrit® <input type="checkbox"/> Aranesp®   | Next Administration Date: ____/____/____  |
| Dispense Qty: _____ Refills: _____ Sig: _____  |   |
| Precision Rx Specialty Solutions is able to fill your ESA request as written. Please provide the following information to expedite your order: |   |
| <input type="checkbox"/> Precision Rx Specialty Solutions to dispense (Check Box)  | Ship to: <input type="checkbox"/> Physician Office <input type="checkbox"/> Patient's home address <input type="checkbox"/> N/A |
| Prescriber's signature: _____  | Date: ____/____/____  |

Anthem UM Services, Inc. is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan

Medical Policy Reference can be found at: <http://empireblue.com/home-providers.html>

Precision Rx Specialty Solutions Client Services: (888) 662-0944

ESA Pre-D Form 011409