Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Erythropoiesis-Stimulating Agents – Medical Necessity Request

Please complete page 1 and 2 for New/Initial Requests

Clinical Values

***Please submit laboratory documentation for hemoglobin taken within the past 60 days.**

Current weight: _____ lbs or kg

Hemoglobin: _____g/dL Date taken: _____

Transferrin Saturation: _____%

Ferritin level: _____ng/mL

Contraindication Information

Does the member have uncontrolled hypertension? **Yes or No**

Has the member had pure red cell aplasia (PRCA) that begins after treatment with an erythropoeitin protein drug such as Procrit, Epogen, Retacrit, Aranesp or Mircera? **Yes or No**

Is the member pregnant or nursing? **Yes or No**

1. Does the member have Anemia? **Yes or No**
   - If no, what is the drug being used for? _____

2. Have other causes of anemia been excluded (e.g. GI bleeding, iron or folate deficiency, hemolysis)? **Yes or No**

3. Is the member currently on iron therapy? **Yes or No**

Please select the cause of anemia and answer related questions.

□ Chronic Kidney Disease/End-Stage Renal Disease
- Will the member be receiving dialysis? **Yes or No** If No, answer the following questions.
  - Is the goal of using this medication to reduce the risk of alloimmunization and/or other red blood cell transfusion-related risks? **Yes or No**
  - Does the member have a rate of hemoglobin decline which would indicate the likelihood of requiring a red blood cell transfusion? **Yes or No**
- For Mircera requests: Is the member converting from another erythropoiesis stimulating agent (ESA**)** after their hemoglobin level was stabilized with and ESA?
  - □ **Yes** - *What was the previous ESA dose?* _____
    - *For members less than 18 years old, is the member receiving hemodialysis?* **Yes or No**
  - □ **No**

□ HIV
- Is member currently receiving AZT (Zidovudine)? **Yes** or **No**
- If yes, please provide the dose that member is receiving _____
- What is the member's serum erythropoietin level in mUnits/mL? _____

□ Cancer/Chemotherapy
- What type of cancer does the member have? _____
- What chemotherapy is the member receiving? _____
- How many month of chemotherapy are planned? _____
- Is the anticipated outcome of the chemotherapy cure? **Yes** or **No**
- Can the anemia be managed by a transfusion? **Yes** or **No**

□ Upcoming Surgery
- Is the patient at high-risk for blood loss from surgery? **Yes or No**
- Would the drug reduce the need for an allogenic blood transfusion (from another person)? **Yes or No**
- Is the member scheduled to undergo elective, non-cardiac, non-vascular surgery? **Yes or No**
- Is the member unable or unwilling to donate autologous blood? **Yes** or **No**

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ Hepatitis C
- Is the member being treated with ribavirin and interferon/PEG interferon? **Yes or No**
- What date will the member complete therapy with ribavirin and interferon/PEG interferon? _____

□ Rheumatoid Arthritis/Rheumatic Disease

□ Myleodysplastic syndrome
- What is the member's serum erythropoietin level in mUnits/mL? _____
- Does the member have a lower-risk disease (i.e., defined as IPSS-R [Very Low, Low, Intermediate], IPSS [Low/Intermediate-1], WPSS [Very Low, Low, Intermediate])? **Yes or No**
- Is the anemia symptomatic**? Yes or No**
- Does the member have del(5q)? **Yes or No**
- Are sideroblasts greater than or equal to 15%**? Yes or No**
- Is the medication being used together with a G-CSF (drugs such as Neupogen, Neulasta, Zarxio, etc.)? **Yes or No**

□ Myelofibrosis
- What is the member's serum erythropoietin level in mUnits/mL? _____

□ Anemia of Prematurity
- Will the requested medication be used in combination with iron supplements? **Yes or No**

□ Other: __

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

****Complete this page ONLY for Subsequent (Renewal) requests or for dosage changes****

General Information

***Please submit laboratory documentation for hemoglobin taken within the past 3 months.**

Hemoglobin: _____g/dL. Date taken: _____ Current Weight: _____ lbs or kg

Transferrin Saturation: _____%. Date taken: _____ Ferritin level: _____ng/mL. Date taken: _____

Previous Dose: _____ New Dose: _____

1. Is the member currently on iron therapy? **Yes or No**
2. Has the member responded to this medication by having an increase in hemoglobin levels? **Yes or No**
3. Has the member responded to this medication by having a decrease in the duration or number of transfusions? **Yes or No**

Please select the cause of anemia and answer related questions.

□ Chronic Kidney Disease/End-Stage Renal Disease
- Will the member be receiving dialysis? **Yes or No**

□ HIV
- Is member currently receiving AZT (Zidovudine)? **Yes or No**
- If yes, please provide the dose that member is receiving _____

□ Cancer/Chemotherapy
- Is the member currently receiving chemotherapy? **Yes or No**
- If yes, what chemotherapy regimen? (Please include all the drugs and how often they are being given)
_____
- How many months of treatment with the above chemotherapy regimen are planned? _____

□ Hepatitis C
- Is the member being treated with ribavirin and interferon/PEG interferon? **Yes or No**
- What date will the member complete therapy with ribavirin and interferon/PEG interferon? _____

□ Rheumatoid Arthritis/Rheumatic Disease

□ Myleodysplastic syndrome

□ Myelofibrosis

□ Anemia of Prematurity
- Will the requested medication be used in combination with iron supplements? **Yes or No**

□ Upcoming/Recent Surgery
- Is the patient at high-risk for blood loss from surgery? **Yes or No**
- Would the drug reduce the need for an allogenic blood transfusion (from another person)? **Yes or No**

□ Other: _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**