

**PRIOR AUTHORIZATION REQUEST FORM**

**EOC ID:**

**ESA - PA Request**



**Phone: 617-252-6366 Fax back to: 1-888-251-7823**

SENIOR WHOLE HEALTH manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

**Patient Name:**

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

**Prescriber Name:**

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:**

Q1. Senior Whole Health will only authorize up to 3 months of ESA products for approved FDA indications only. Patients with hemoglobin levels above 12g/dl will not be approved. Please check which product is being requested.

Aranesp

Epogen

Procrit (Preferred over Epogen)

Q2. Please indicate Dose and Frequency of administration above. Is this dose above 40,000 units weekly for Procrit or Epogen?

Yes

No

Q3. The only approved FDA indication for these products is anemia associated with a primary cause. Please check the associated diagnosis:

CKD (Chronic Kidney Disease)

Chemotherapy

HIV & Zidovudine Therapy

Myelodysplastic Syndrome

Other

Q4. If other, please specify:

Q5. Senior Whole Health requires that the blood work is current for review. Is the blood work from within the last 30 days?

Yes

No

Q6. Please enter date of the bloodwork \_\_\_/\_\_\_/\_\_\_ and the follow lab values:Hgb: \_\_\_\_\_g/dl - HCT \_\_\_\_\_ - Serum Ferritin: \_\_\_\_\_ng/ml - Transferrin Saturation: \_\_\_\_\_%

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**Patient Name:**

**Prescriber Name:**

Q7. Please indicate the Hgb Range stated in the above lab values:

Less than 11g/dl

From 11g/dl to 12g/dl

Over 12g/dl

Q8. Is the ferritin less than 100ng/ml or the transferrin saturation less than 20%?

Yes No

Q9. Is the patient currently on an iron supplement?

Yes No

Q10. Is the patient on Dialysis or Predialysis?

Yes No

Q11. Does the patient have a history of hypertension?

Yes No

Q12. If yes, is the hypertension under control?

Yes No

Q13. Does the patient have a history of seizures?

Yes No

Q14. If yes, please provide detail and how the patient is controlled?

Q15. Where will the drug be dispensed?

Dispensing Pharmacy

MD office (J Code \_\_\_\_\_)

Q16. Please include any clinically significant information below:

**Physician Signature**

**Date**