Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Retacrit_Procrit_Epogen

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Has the patient been assessed for iron deficiency anemia and have adequate iron stores (defined as a serum transferrin saturation [TSAT] level greater than or equal to 20% within the prior 3 months) or are they receiving iron therapy? Please attach labs/documentation.

☐ Yes ☐ No

Q2. Is the patient using the requested medication concomitantly with other erythropoiesis stimulating agents?

☐ Yes ☐ No

Q3. Is this an initial or continuation request?

☐ Initial - Go to 4 ☐ Continuation - Go to 5

Q4. Please select the indication the medication is prescribed for:

☐ Treatment of anemia due to chronic kidney disease with pretreatment hemoglobin less than 10 g/dL

☐ Treatment of anemia due to myelosuppressive chemotherapy with nonmyeloid malignancy and pretreatment hemoglobin less than 10 g/dL

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☐ Treatment of anemia in myelodysplastic syndrome in patients with pretreatment hemoglobin < 10 g/dL

☐ Reduction of allogenic red blood cell transfusion in patients scheduled to have an elective, noncardiac, nonvascular surgery with pretreatment hemoglobin less than or equal to 13 g/dL

☐ Treatment of anemia due to zidovudine in HIV-infected patients currently receiving zidovudine with pretreatment hemoglobin less than 10 g/dL whose pretreatment serum EPO level is less than 500 mU/mL

☐ Treatment of anemia in patients who will not/cannot receive blood transfusions (e.g., religious beliefs) with pretreatment hemoglobin < 12 g/dL.

☐ Treatment of anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis in patients who meet ALL of the following criteria:
i. Pretreatment hemoglobin less than 10 g/dL
ii. Pretreatment serum EPO level less than 500 mU/mL

☐ Treatment of anemia due to cancer in patients who have cancer and are undergoing palliative treatment.

Q5. Does the patient have Anemia Due to Zidovudine in HIV-infected patient?

☐ Yes ☐ No

Q6. Has the patient completed 12 weeks of treatment with the erythropoeiesis-stimulating agent (ESA)?

☐ Yes ☐ No

Q7. Has the patient completed less than 12 weeks of ESA treatment and has not yet responded with a rise in hemoglobin of greater than or equal to 1g/dL? Please attach labs/documentation.

☐ Yes ☐ No

Q8. For continuation of therapy after at least 12 weeks of treatment with the ESA for for Anemia due to CKD, Anemia Due to Myelosuppressive Chemotherapy, Anemia in MDS, Reduction of Allogenic Red Blood Cell Transfusion in Patients Undergoing Elective, Noncardiac, Nonvascular Surgery, Anemia in Members Who Will Not/Cannot Receive Blood Transfusions, Myelofibrosis-associated Anemia, and Anemia Due to Cancer, is there documentation showing a response to treatment with a rise in hemoglobin of > 1 g/dL?

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☐ Yes ☐ No

Q9. Is the request for a diagnosis of Reduction of Allogenic Red Blood Cell Transfusion in Patients Undergoing Elective, Noncardiac, Nonvascular Surgery?

☐ Yes ☐ No

Q10. Does the patient meet all initial authorization criteria?

☐ Yes ☐ No

Q11. Does the patient have a current hemoglobin less than 12 g/dL? Please attach labs/documentation.

☐ Yes ☐ No

Q12. Additional Information:

_____ _____

Prescriber Signature Date

v2025