Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Erythropoiesis Stimulating Proteins

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

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. Does the patient have the diagnosis of anemia associated with chronic kidney disease?

☐ Yes ☐ No

Q2. Is this a request for continuation of therapy with the requested drug?

☐ Yes ☐ No

Q3. Does the patient have irreversible chronic kidney disease as defined by the National Kidney Foundation's Kidney Disease Outcome Quality Initiative (KDOQI)?

☐ Yes ☐ No

Q4. Does the patient meet all of the following: 1) Hemoglobin less than 10 g/dL, 2) Transferrin or iron saturation greater than or equal to 20 percent and ferritin greater than or equal to 100 ng/mL?

☐ Yes ☐ No

Q5. Is this a request for a pediatric patient?

☐ Yes ☐ No

Q6. Is the requested drug being prescribed by or in consultation with a specialist in hematology or nephrology?

☐ Yes ☐ No

Q7. Has the patient experienced a documented increase in hemoglobin?

☐ Yes ☐ No

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Q8. Does the patient meet all of the following: 1) Hemoglobin less than or equal to 10 g/dL if the patient is not on dialysis, 2) Hemoglobin less than or equal to 11 g/dL for patients on dialysis, 3) Transferrin or iron saturation greater than or equal to 20 percent and ferritin greater than or equal to 100 ng/mL?

☐ Yes ☐ No

Q9. Does the patient have anemia while on chemotherapy?

☐ Yes ☐ No

Q10. Is this a request for continuation of therapy with the requested drug?

☐ Yes ☐ No

Q11. Is the patient currently receiving myelosuppressive chemotherapy?

☐ Yes ☐ No

Q12. Does the patient meet all of the following: 1) Hemoglobin less than 10 g/dL, 2) Transferrin or iron saturation greater than or equal to 20 percent and ferritin greater than or equal to 100 ng/mL?

☐ Yes ☐ No

Q13. Has the patient experienced a documented increase in hemoglobin?

☐ Yes ☐ No

Q14. Does the patient meet all of the following: 1) Hemoglobin less than or equal to 12 g/dL, 2) Transferrin or iron saturation greater than or equal to 20 percent and ferritin greater than or equal to 100 ng/mL?

☐ Yes ☐ No

Q15. Will the requested drug be used to treat anemia in a patient taking zidovudine for human immunodeficiency virus (HIV) infection?

☐ Yes ☐ No

Q16. Is this a request for a continuation of therapy with the requested drug?

☐ Yes ☐ No

Q17. Is the patient receiving 4200 mg/week of zidovudine or greater?

☐ Yes ☐ No

Q18. Does the patient meet all of the following: 1) Serum erythropoietin level less than or equal to 500 mUnits/mL, 2) Hemoglobin less than or equal to 10 g/dL, 3) Transferrin or iron saturation greater than or equal to 20 percent and ferritin greater than or equal to 100 ng/mL?

☐ Yes ☐ No

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Q19. Has the patient experienced a documented increase in hemoglobin?

☐ Yes ☐ No

Q20. Does the patient meet all of the following: 1) Hemoglobin less than or equal to 12 g/dL, 2) Transferrin or iron saturation greater than or equal to 20 percent and ferritin greater than or equal to 100 ng/mL?

☐ Yes ☐ No

Q21. Will the requested drug be used to reduce allogenic blood transfusion in a surgical patient?

☐ Yes ☐ No

Q22. Is the patient undergoing elective, noncardiac, nonvascular surgery?

☐ Yes ☐ No

Q23. Does the patient meet all of the following: 1) Hemoglobin greater than 10 g/dL but less than or equal to 13 g/dL, 2) Transferrin or iron saturation greater than or equal to 20 percent and ferritin greater than or equal to 100 ng/mL?

☐ Yes ☐ No

Q24. Will the requested drug be used to treat anemia caused by ribavirin in a patient being treated for hepatitis C?

☐ Yes ☐ No

Q25. Is this a request for a continuation of therapy with the requested drug?

☐ Yes ☐ No

Q26. Does the patient meet all of the following: 1) Hemoglobin less than 10 g/dL if asymptomatic, or hemoglobin less than 11 g/dL if symptomatic, 2) Transferrin or iron saturation greater than or equal to 20 percent and ferritin greater than or equal to 100 ng/mL?

☐ Yes ☐ No

Q27. Has the patient experienced a documented increase in hemoglobin?

☐ Yes ☐ No

Q28. Does the patient meet all of the following: 1) Hemoglobin less than or equal to 12 g/dL, 2) Transferrin or iron saturation greater than or equal to 20 percent and ferritin greater than or equal to 100 ng/mL?

☐ Yes ☐ No

Q29. Has the provider evaluated the patient's vitamin B12 and folate levels and will supplement as indicated?

☐ Yes ☐ No

Q30. Does the patient have adequately controlled blood pressure?

☐ Yes ☐ No

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Q31. Is the request for a non-preferred product?

☐ Yes ☐ No

Q32. Does the patient have a documented history of therapeutic failure, contraindication or intolerance of the preferred erythropoiesis stimulation proteins?

☐ Yes ☐ No

Q33. Additional Information:

Prescriber Signature

Date

Updated for 2020