

## Erythropoiesis Stimulating Agents (ESAs)

**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.**

Member Name:		Prescriber Name:	
HPP Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Primary Phone:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

**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. Is the prescribed ESA being used for the treatment of a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

Yes

No

Q2. Is the prescribed ESA by or in consultation with an appropriate specialist (i.e., gastroenterologist, hematologist/oncologist, infectious disease specialist, nephrologist, surgeon, etc)?

Yes

No

Q3. Does the patient have a contraindication to the prescribed ESA?

Yes

No

Q4. Is the prescribed dose and duration of therapy consistent with FDA- approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q5. Has the patient been evaluated and treated for other causes of anemia (e.g. iron deficiency, hemolysis, vitamin B12 deficiency, folate deficiency, etc)?

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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Does the patient have a serum ferritin $\geq 100$ mcg/L and serum transferrin saturation $\geq 20\%$ OR receiving supplemental iron therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Does the patient have the diagnosis of anemia associated with chronic kidney disease?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is this a request for continuation of therapy with the requested drug?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Does the patient have a pretreatment hemoglobin $\leq 10$ g/dL?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Has the patient experienced a documented increase in hemoglobin or is prescribed an increased dose of the requested ESA consistent with FDA approved package labeling or peer reviewed medical literature?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. 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) Has serum ferritin greater than or equal to 100 mcg/L and serum transferrin saturation greater than or equal to 20% OR is receiving supplemental iron therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Does the patient have anemia while on chemotherapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Is this a request for continuation of therapy with the requested drug?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Member Name:	Prescriber Name:
<p>Q14. Does the patient have a pretreatment hemoglobin less than or equal to 10 g/dL?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q15. Is the patient currently receiving myelosuppressive chemotherapy and the anticipated outcome is not cure?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q16. Has the patient experienced a documented increase in hemoglobin or is prescribed an increased dose of the requested ESA consistent with FDA approved package labeling or peer reviewed medical literature?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q17. Does the patient meet all of the following: 1) Hemoglobin less than or equal to 12 g/dL 2) Has serum ferritin greater than or equal to 100 mcg/L and serum transferrin saturation greater than or equal to 20% OR is receiving supplemental iron therapy?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q18. Will the requested drug be used to treat anemia due to zidovudine in beneficiaries with HIV infection?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q19. Is this a request for a continuation of therapy with the requested drug?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q20. Has the patient experienced a documented increase in hemoglobin or is prescribed an increased dose of the requested ESA consistent with FDA approved package labeling or peer reviewed medical literature?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q21. Does the patient meet all of the following: 1) Has Hemoglobin less than or equal to 12 g/dL, 2) Has a serum erythropoietin level less than or equal to 500 mUnits/mL, 3) is receiving a dose of zidovudine less than or equal to 4200 mg/week 4) Has serum ferritin greater than or equal to 100</p>	

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<p>mcg/L and serum transferrin saturation greater than or equal to 20% OR is receiving supplemental iron therapy?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q22. Will the requested drug be used to reduce allogenic blood transfusion in a surgical patient?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q23. Does the patient meet all of the following: 1) Pretreatment Hemoglobin greater than 10 g/dL but less than or equal to 13 g/d; , 2) Is undergoing elective, non cardiac, non vascular surgery?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q24. Is the request for a non-preferred product?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q25. Is this a request for continuation of therapy with the requested drug?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q26. Has the patient experienced a documented increase in hemoglobin or is prescribed an increased dose of the requested ESA consistent with FDA approved package labeling or peer reviewed medical literature?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q27. Does the patient meet the following: 1) Has serum ferritin greater than or equal to 100 mcg/L and serum transferrin saturation greater than or equal to 20% OR is receiving supplemental iron therapy?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q28. Does the patient have a documented history of therapeutic failure, contraindication or intolerance of the preferred erythropoiesis stimulation proteins approved or medically accepted for the beneficiary's diagnosis?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	

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Member Name:	Prescriber Name:
Q29. Additional Information:	
Q30. Buy & Bill:  <input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span>	
Q31. If using Specialty pharmacy, which pharmacy will be used:	
Q32. How will drug be billed:  <input type="checkbox"/> Buy & Bill <span style="margin-left: 150px;"><input type="checkbox"/> Specialty Pharmacy</span>	

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 Prescriber Signature

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 Date

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