# Medical drug benefit
# Prior authorization request

WellSense HEALTH PLAN

## Aranesp, Epogen, Mircera, Procrit and Retacrit

Version20 Effective: 06/26/2023


Phone: 877-417-1822 (MassHealth)
877-417-0528 (Clarity plans)
877-417-1839 (NH Medicaid)
Fax: 866-539-7185


* Some plans might not accept this form for Medicare or Medicaid requests

| **This form is being used for:** | |
|---|---|
| Check if Expedited Review/Urgent Request: | ☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.) |

| **1. Patient Information** | |
|---|---|
| Patient Name: | DOB: |
| Member ID #: | |

| **2. Prescriber Information** | |
|---|---|
| Prescribing Clinician: | Phone #: |
| Specialty: | Secure Fax #: |
| NPI #: | DEA/xDEA: |
| Prescriber Point of Contact Name (POC) (if different than provider): | |
| POC Phone #: | POC Secure Fax #: |
| POC Email (not required): | |
| Prescribing Clinician or Authorized Representative Signature: | Date: |

| **3. Drug Request** | |
|---|---|
| Please select the drug you are requesting (select **one**): | |
| ☐ Aranesp (proceed to Q4, then Q5) | ☐ Epogen (proceed to Q4, then Q5) |
| ☐ Mircera (proceed to Q4, then Q6) | ☐ Procrit (proceed to Q4, then Q6) |



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☐ Retacrit (proceed to Q4, then Q6)

## 4. Requested Dosing

Please document the requested dosing:

## 5. For Aranesp or Epogen:

Does the member have any of the following conditions? Please select **any** of the following that apply:

☐ Member has anemia associated with cancer and is not receiving myelosuppressive cancer chemotherapy

☐ Member has anemia associated with Acute Myelogenous Leukemias, Chronic Myelogenous Leukemias or other myeloid cancers

☐ Member has anemia associated with radiotherapy in cancer

☐ Member is using the requested medication to enhance athletic performance

☐ Member has anemia due to acute blood loss

☐ Member is non anemic (Hemoglobin > 13.0g/dL) prior to surgery

☐ None of the above

## 6. Please choose one of the following

☐ Anemia with chronic kidney disease and on dialysis (proceed to Q19)

☐ Other conditions (for Aranesp, Epogen and Mircera, proceed to Q7)

☐ Other conditions (for Procrit and Retacrit, proceed to Q8)

## 7. For Aranesp, Epogen or Mircera:

Please choose **all** of the following that apply: (Proceed to Q8)

☐ Member has tried Procrit or Retacrit or both

☐ Member cannot continue to use Procrit or Retacrit due to a formulation difference in the inactive ingredient(s) [e.g. differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction

☐ Other (please specify):

## 8. Diagnosis

What is the diagnosis the requested medication is being used to treat (select one)

☐ Anemia in a member with chronic kidney disease who is not on dialysis

☐ Anemia in a member with cancer due to cancer chemotherapy

☐ Anemia associated with Myelodysplastic Syndrome

☐ Anemia associated with myelofibrosis

☐ Anemia in a member with Human Immunodeficiency Virus who is receiving Zidovudine

☐ Reduction of allogenic red blood cell transfusions in a member undergoing surgery

☐ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request detailing member's clinical status, dose and dates of all previous therapies and outcomes, proper succession of therapies that have been tried and failed and any related lab work and test results.

## 9. Initial or Continuing Therapy:

Is the request for initial or continuing therapy:

☐ Initial

☐ Continuation (proceed to Q15)

## 10. Anemia in a member with chronic kidney disease who is not on dialysis

Please choose **all** of the following that apply (Proceed to Q18)

☐ Member is ≥ 18 years of age with a hemoglobin < 10.0 g/dL

☐ Member is < 18 years of age with a hemoglobin ≤ 11.0 g/dL

☐ Member is currently receiving iron therapy

☐ Member has adequate iron stores

☐ Other (please specify)

## 11. Anemia in a member with cancer due to cancer chemotherapy

Please choose **all** of the following that apply (Proceed to Q18):

| | |
|---|---|
| ☐ Member has a hemoglobin < 10.0 g/dL | ☐ Member is currently receiving myelosuppressive chemotherapy |
| ☐ Member is currently receiving iron therapy | ☐ Member has adequate iron stores |

☐ Other (please specify)

## 12. Anemia associated with Myelodysplastic Syndrome or anemia associated with myelofibrosis

Please choose **all** of the following that apply (Proceed to Q18):

| | |
|---|---|
| ☐ Member has a hemoglobin < 10.0 g/dL | ☐ Member has a serum erythropoietin level ≤ 500 mU/mL |
| ☐ Member is currently receiving iron therapy | ☐ Member has adequate iron stores |

☐ Other (please specify)

## 13. Anemia in a member with Human Immunodeficiency Virus who is receiving Zidovudine:

Please choose **all** of the following that apply (Proceed to Q18):

| | |
|---|---|
| ☐ Member has a hemoglobin < 10.0 g/dL | ☐ Member has a serum erythropoietin level ≤ 500 mU/mL |
| ☐ Member is currently receiving zidovudine therapy | ☐ Member is currently receiving iron therapy |
| ☐ Member has adequate iron stores according to the prescriber | |

☐ Other (please specify)

## 14. Reduction of allogenic red blood cell transfusions in a member undergoing surgery:

Please choose all of the following that apply (Proceed to Q18)

| | |
|---|---|
| ☐ Hemoglobin < 13.0 g/dL | ☐ The surgery is elective, nonvascular and noncardiac |
| ☐ Member is not willing or able to donate autologous blood prior to surgery | ☐ Member is currently receiving iron therapy |
| ☐ Member has adequate iron stores | |

☐ Other (please specify)

## 15. For continuation of therapy:

Please select the appropriate diagnosis

☐ Anemia in a member with chronic kidney disease who is not in dialysis (proceed to Q16)

☐ Anemia in a member with cancer due to chemotherapy (proceed to Q17)

☐ Anemia associated with myelodysplastic syndrome (proceed to Q17)

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☐ Anemia associated with myelofibrosis (proceed to Q17)

☐ Anemia in a member with human immunodeficiency virus who is receiving Zidovudine (proceed to Q17)

## 16. Anemia in a member with chronic kidney disease who is not on dialysis

Please choose **all** that apply (proceed to Q18):

| | |
|---|---|
| ☐ Member is ≥ 18 years of age with a hemoglobin < 11.5 g/dL | ☐ Member is < 18 years of age with a hemoglobin ≤ 12.0 g/dL |
| ☐ Member is currently receiving iron therapy | ☐ Member has adequate iron stores |

☐ Other (please specify):

## 17. Anemia in a member with cancer due to cancer chemotherapy, anemia associated with Myelodysplastic Syndrome, anemia associated with myelofibrosis, anemia in a member with Human Immunodeficiency Virus who is receiving Zidovudine

Please choose **all** of the following that apply (Proceed to Q18)

☐ Member has a hemoglobin ≤ 12.0 g/dL

☐ Member has responded to therapy defined as hemoglobin ≥ 10 g/dL or a hemoglobin increase of ≥ 2 g/dL

☐ Member is currently receiving myelosuppressive chemotherapy

☐ Member is currently receiving Zidovudine therapy

☐ Member is currently receiving iron therapy

☐ Member has adequate iron stores

☐ Other (please specify):

## 18. Specialty of the prescriber

Please indicate what specialty the prescriber is (select any that apply):

| | |
|---|---|
| ☐ Hematologist | ☐ Nephrologist |
| ☐ Oncologist | |

☐ Other (please indicate what specialty below)

## 19. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits *(using the space below):*

☐ HCPCS / Qcodes:

☐ Number of units:

☐ Number of visits:

**Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.**