CVS CAREMARK

Fax Referral To: 800-323-2445
Phone: 866-278-6634

Epogen® & Procrit® (epoetin alfa)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code):

☐ 248.8 Aplastic Anemia due to chronic system disease, drugs, infection, radiation, toxic (paralytic)
☐ 285.21 Anemia of chronic renal failure
☐ 285.29 Anemia of other chronic illness
☐ 042 Human Immunodeficiency Virus (HIV)
☐ 070.54 Hepatitis C (Chronic)
☐ Other: _____
• Date of Diagnosis: _____

☐ 285.9 Reduction of allogenic blood transfusion in patients with anemia (Hgb 10-13) scheduled to undergo elective, noncardiac, nonvascular surgery
☐ 585.1 Chronic Kidney Disease (CKD) *Stage 1*
☐ 585.2 Chronic Kidney Disease (CKD) *Stage 2 (mild)*
☐ 585.3 Chronic Kidney Disease (CKD) *Stage 3*
☐ 585.4 Chronic Kidney Disease (CKD) *Stage 4 (severe)*
☐ 585.5 Chronic Kidney Disease (CKD) *Stage 5*
☐ Secondary Diagnosis (if applicable): _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

• Is patient continuing therapy with the requested drug? ☐ Yes ☐ No

Requests will only be approved for 2 months at a time. An additional request for those patients who require treatment beyond 2 months will have to be submitted and the following criteria met, in addition to the above.

• Has the patient tried and failed or is intolerant to Procrit? ☐ Yes ☐ No
• Does Hgb exceed 12 g/dl? ☐ Yes ☐ No • Please specify current Hgb: _____ g/dl
• Are iron stores (including transferrin saturation and ferritin) adequately maintained and monitored periodically during therapy? ☐ Yes ☐ No

If patient is currently on Procrit or Epogen:

• Has the patient had a sudden loss of response with severe anemia and low reticulocyte count? ☐ Yes ☐ No
• Has it been ≥ 8 weeks since chemotherapy was completed? ☐ Yes ☐ No
• Has the patient demonstrated a response to therapy? ☐ Yes ☐ No

ALL of the following criteria must be met:

• Patient has hematocrit (Hct)/hemoglobin (Hgb) levels less than 32% / 10 g/dl, prior to initiation of therapy (unless otherwise specified below) ☐ Yes ☐ No
• Patient's iron status, prior to and during therapy, including transferrin saturation and serum ferritin, is evaluated with transferrin saturation at least 20% and ferritin at least 100 ng/ml prior to initiation of therapy ☐ Yes ☐ No
• Patients with uncontrolled hypertension, blood pressure is adequately controlled before initiation of therapy and closely monitored and controlled during therapy ☐ Yes ☐ No

ONE of the following criteria must be met:

• Patient has anemia of chronic renal failure and one of the following: ☐ Yes ☐ No
  • Patient is on dialysis [end-stage renal disease (ESRD)] ☐ Yes ☐ No
  • Patient is on dialysis with <10g/dl ☐ Yes ☐ No
• Treatment of anemia induced by concomitantly administered chemotherapy known to produce anemia, in patients with a diagnosis of any of the following: ☐ Yes ☐ No
  • Cancer, excluding acute leukemia ☐ Yes ☐ No
  • Chronic inflammatory disease ☐ Yes ☐ No
• Patient has Myelodysplastic syndrome with endogenous erythropoietin level is ≤500 mUnits/ml ☐ Yes ☐ No
• Treatment of anemia related to therapy with zidovudine in HIV-infected patients ☐ Yes ☐ No
• Patient's endogenous serum erythropoietin level is ≤500 mUnits/ml and the dose of zidovudine is ≤4200 mg/week ☐ Yes ☐ No
• Treatment of preoperative anemia to reduce the need for allogeneic blood transfusions when the patient meets the following: ☐ Yes ☐ No
  • Patient's hemoglobin >10 to ≤13 g/dl ☐ Yes ☐ No
  • Patient is scheduled to undergo elective, non cardiac, nonvascular surgery ☐ Yes ☐ No
  • Patient at high risk for preoperative transfusions with significant, anticipated blood loss ☐ Yes ☐ No
  • Patient is unable or unwilling to donate autologous blood ☐ Yes ☐ No
  • Antithrombotic prophylaxis has been considered ☐ Yes ☐ No

- Patient has hepatitis C virus infection ☐ Yes ☐ No
- Patient is being concomitantly treated with the combination of ribavirin and interferon alfa, or ribavirin and peginterferon alfa ☐ Yes ☐ No
- Patient is following allogeneic bone marrow transplantation ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Epogen® (epoetin alfa)				
☐ Procrit® (epoetin alfa)	☐ 2,000 U/ml ☐ 10,000 U/ml ☐ 3,000 U/ml ☐ 20,000 U/ml ☐ 4,000 U/ml ☐ 40,000 U/ml ☐Single Use Vial ☐Multidose Vial	☐ Single Use Vial: Inject the entire contents of 1 vial **subcutaneously** ☐Once a Week ☐3 Times a Week ☐Other: _____ ☐ Mulitdose Vial: Inject _____ml (_____units) subcutaneously ☐Once a Week ☐3 Times a Week ☐Other: _____		

PRODUCT SUBSTITUTION PERMITTED (Date)

DISPENSE AS WRITTEN (Date)