Retacrit (epoetin alfa-epbx)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Reduction of allogenic blood transfusions in elective, non-cardiac, non-vascular surgery ☐ Secondary anemia ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For <u>reduction of allogenic blood transfusions in elective, non-cardiac, non-vascular surgery</u>, also answer the following:
Does the patient have a hematocrit level between 30 to 39 percent and/or hemoglobin between 10 to 13 g/dL?*
☐ Yes ☐ No
Please provide documentation

Were lab tests showing low hematocrit and/or hemoglobin levels administered within 30 days of this request?
☐ Yes ☐ No

For <u>secondary anemia</u>, also answer the following:
Select the primary cause of the secondary anemia for the patient:
☐ Chronic kidney disease with dialysis
☐ Chronic kidney disease without dialysis
☐ Multiple myeloma
☐ Myelosuppressive chemotherapy
☐ Myelodysplastic syndrome
☐ Hepatitis C therapy with ribavirin and interferon treatment
☐ Other_____

<u>Secondary anemia due to chronic kidney disease with dialysis or myelodysplastic syndrome</u>, answer the following:
Does the patient have a hematocrit less than 33 percent and/or hemoglobin less than 11 g/dL? ☐ Yes ☐ No
Please provide documentation

Were lab tests showing low hematocrit and/or hemoglobin levels administered within 30 days of this request?
☐ Yes ☐ No

<u>Secondary anemia due to chronic kidney disease without dialysis, multiple myeloma, or myelosuppressive chemotherapy treatment within the last 6 weeks,</u> answer the following:

Does the patient have a hematocrit less than 30 percent and/or hemoglobin less than 10 g/dL? □ Yes □ No
Please provide documentation

Were lab tests showing low hematocrit and/or hemoglobin levels administered within 30 days of this request?
□ Yes □ No

<u>Secondary anemia due to Hepatitis C therapy with ribavirin and interferon</u>, answer the following:
Was the patient's ribavirin and interferon dose reduced after the onset of anemia? □ Yes □ No

Does the patient have a hematocrit less than 33 percent and/or hemoglobin less than 11 g/dL? □ Yes □ No
Please provide documentation

Were lab tests showing low hematocrit and/or hemoglobin levels administered within 30 days of this request?
□ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811