pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ERYTHROPOIESIS STIMULATING AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/3/2022)*

Prior authorization guidelines for Erythropoiesis Stimulating Agents are available on the DHS Pharmacy Services website at: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength & vial size:	☐single-dose vial ☐multi-dose vial
Dose/directions:	Quantity:	Duration:
Diagnosis *(submit documentation)*:	Dx code (*required*):	
For non-preferred medication: Does the beneficiary have a history of trial and failure of or contraindication or an intolerance to the preferred agents in this class that are approved or medically accepted for the beneficiary's diagnosis? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes ☐No	*Submit documentation.*

INITIAL requests

Complete the section(s) below applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Is prescribed the ESA by or in consultation with a specialist *(submit documentation of consultation if applicable)*
☐Has transferrin or iron saturation ≥20% and ferritin ≥100 ng/mL
☐Is receiving supplemental iron therapy
☐Has adequately controlled blood pressure
☐Was evaluated and treated for other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency, folate deficiency, etc.)

☐For treatment of anemia associated with CHRONIC KIDNEY DISEASE:
- ☐Has pretreatment hemoglobin <10 g/dL

☐For treatment of anemia in beneficiaries with CANCER RECEIVING CHEMOTHERAPY:
- ☐Is currently receiving myelosuppressive chemotherapy
- ☐Is receiving chemotherapy with a non-curative intent
- ☐At initiation of therapy with an ESA, has an additional 2 or more months of planned chemotherapy
- ☐Has pretreatment hemoglobin <10 g/dL

☐For treatment of anemia in beneficiaries with HIV INFECTION RECEIVING ZIDOVUDINE:
- ☐Has a serum erythropoietin level ≤500 mU/mL
- ☐Is taking zidovudine at a dose of ≤4200 mg/week

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☐ Has pretreatment hemoglobin <10 g/dL

☐ For reduction of ALLOGENEIC BLOOD TRANSFUSIONS in beneficiaries undergoing SURGERY:
- ☐ Will be undergoing elective, non-cardiac, non-vascular surgery
- ☐ Is at high risk for perioperative blood loss
- ☐ Is not willing to donate autologous blood pre-operatively
- ☐ Has pretreatment hemoglobin >10 g/dL and ≤13 g/dL

RENEWAL requests

Complete the section(s) below applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ Experienced an increase in hemoglobin compared to baseline
☐ Is prescribed an increased dose of the requested ESA
☐ Has transferrin or iron saturation ≥20% and ferritin ≥100 ng/mL
☐ Is receiving supplemental iron therapy
☐ Has adequately controlled blood pressure

☐ For treatment of anemia associated with CHRONIC KIDNEY DISEASE:
- ☐ Is receiving dialysis and has a hemoglobin ≤11 g/dL
- ☐ Is not receiving dialysis and has a hemoglobin ≤10 g/dL

☐ For treatment of anemia in beneficiaries with CANCER RECEIVING CHEMOTHERAPY:
- ☐ Has a hemoglobin ≤12 g/dL

☐ For treatment of anemia in beneficiaries with HIV INFECTION RECEIVING ZIDOVUDINE:
- ☐ Has a serum erythropoietin level ≤500 mU/mL
- ☐ Is taking zidovudine at a dose of ≤4200 mg/week
- ☐ Has a hemoglobin ≤12 g/dL

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: