VIVA MEDICARE

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EPOGEN, PROCRIT COVERAGE DETERMINATION FORM

Please Note Any Incomplete or Illegible Information Will Delay the Review Process

Patient Information:	Prescriber Information:
Patient Name:	**Physician:**
Member ID #:	**Office Phone #:**
Date of Birth:	**Office Fax #:**
Phone #:	**DEA #:**
Address:	**Office Contact:**

Medication and Diagnosis Information:		
Medication:	**Strength:**	
Route:	**Frequency:**	**Quantity:**

Coverage Criteria Questions:		
ICD Code/Diagnosis:		
1. Is the patient's pretreatment (no erythropoietin treatment in previous month) Hgb <10 g/dL?	Y	N
2. For reauthorizations, did the patient's Hgb increase by at least 1 g/dL after at least 12 weeks of therapy?	Y	N
3. Does the patient have uncontrolled hypertension?	Y	N
4. Is the medication being used to facilitate a preoperative autologous blood donation?	Y	N
5. Does the patient have a diagnosis of anemia associated with:		
a. Chemotherapy? (answer question set **6**)	Y	N
b. CKD? (answer question set **7**)	Y	N
c. Zidovudine use in HIV? (answer question set **8**)	Y	N
d. MDS? (answer question set **9**)	Y	N

6. For a diagnosis of anemia associated with chemotherapy:

a. Is the patient receiving chemotherapy with a curative intent? Y N
b. Is the patient receiving concomitant myelosuppressive chemotherapy? Y N
c. Does the patient have myeloid cancer? Y N
d. Will the patient be receiving at least 2 more months of chemotherapy? Y N
e. Does the patient have a current Hgb <10 g/dL? Y N
f. Does the patient have a current Hgb ≥10 g/dL but <11 g/dL and is symptomatic? Y N

7. For a diagnosis of anemia associated with CKD:

a. If not on dialysis, does the patient have a Hgb ≤ 10? Y N
b. If not on dialysis, does the patient have a Hgb >10 but ≤12 and the prescriber will reduce or interrupt the dose? Y N
c. If on dialysis, does the patient have a Hgb ≤11 g/dL? Y N
d. If on dialysis, does the patient have a Hgb >11 but ≤12 and the prescriber will reduce or interrupt dose? Y N

8. For a diagnosis of anemia associated with zidovudine use in HIV:

a. Is the patient concomitantly using zidovudine at a maximum dose of 4200 mg/week? Y N
b. Does the patient have a Hgb ≤11 g/dL? Y N
c. Does the patient have a Hgb >11 but ≤12 and the prescriber will reduce or interrupt dose? Y N

9. For a diagnosis of anemia associated with MDS?

a. Is the patient's pretreatment serum erythropoietin level ≤500 mU/mL? Y N
b. Does the patient have a Hgb ≤11 g/dL? Y N
c. Does the patient have a Hgb >11 but ≤12 and the prescriber will reduce or interrupt dose? Y N

10. For patients receiving surgical allogeneic prophylaxis:

a. Is the patient at high risk for perioperative blood loss and scheduled for elective, noncardiac, nonvascular surgery? Y N
b. Is the patient's pretreatment Hgb >10 but ≤13 g/dL? Y N

11. Will the patient be monitored for thrombotic and cardiac events? Y N

12. If the patient is diagnosed with a condition not mentioned above, please explain.

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Request Type:	Required Information:
☐ **Prior Authorization**	**View Prior Authorization & Step Therapy Criteria at:** www.vivamedicaremember.com/Resource/Current/Formulary.aspx
☐ **Quantity Exception:**	Request for an exception to the plan's limit on the number of pills available per month. The prescriber must provide clinical documentation that the restricted dose has been found to be ineffective and all other formulary alternatives have been found to be, or based on sound clinical judgment would likely be, ineffective.
☐ **Tier Exception:**	Request for an exception to the tier level for a covered drug. The prescriber must provide information that the drug in the lower-cost sharing tier for the treatment of the member's condition was tried and failed, is contraindicated, or would not be as effective as the drug in the higher cost-sharing tier or would have adverse effects. Limitations: Cannot request a tier exception for Tier 5 Specialty medications, or brand medications for generic tier cost-sharing, or for drugs approved as a formulary exception.

Rationale for Request: (Required)

Prescriber's Signature: **Date:**

Prescriber's Specialty:

Request for Expedited Review:

☐ By checking this box, I certify that waiting 72 hours for a standard review may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

For Urgent Requests Needed Within 24 Hours Please Provide an After-Hours Contact and Direct Phone Number: _____