



Date _____

Client _____

PRIOR AUTHORIZATION QUESTIONNAIRE - ERYTHROPOETINS

M.D. Last Name: _____ **M.D. First Name:** _____

Physician Phone: _____ **Physician Fax:** _____

Patient _____ **ID#** _____ **DOB** _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Requested Product: Procrit _____ Epogen _____ Aranesp _____

2. Please indicate patient's diagnosis:

- Anemia associated with chronic renal failure (MEMBER IS A DIALYSIS PATIENT)
- Anemia associated with chronic renal failure (MEMBER IS A NON-DIALYSIS PATIENT)
- Anemia in cancer patients on chemotherapy AND patient has a non-myeloid malignancy.
- Anemia associated with zidovudine (AZT) therapy in HIV-infection and AZT dose is $\leq 4,200$ mg/week
- Reduction of allogeneic blood transfusion in surgery patients.
- *Other diagnosis: _____

***If diagnosis is "Other" please attach a study to support this off-label request**

3. Please provide the most recent laboratory evidence:

Hemoglobin (g/dl) _____

Hematocrit _____

Serum ferritin (ng/ml) (FOR CRF ONLY) _____

Transferrin saturation (%) (FOR CRF ONLY) _____

4. Patient's weight _____

5. Strength _____ SIG: _____

6. Quantity _____ Duration of Therapy: _____

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

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QUESTIONS PLEASE CALL:
877-526-9906