Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Erythropoiesis-Stimulating Agents – Medical Necessity Request

Please complete page 1 for New/Initial Requests

1. Does the member have Anemia? **Yes or No**
   - If no, what is the drug being used for? _____
2. Have other causes of anemia been excluded (e.g. GI bleeding, iron or folate deficiency, hemolysis)? **Yes or No**
3. Is the member currently on iron therapy? **Yes or No**
4. Does the member have sickle cell disease? **Yes or No**

Please select the cause of anemia and answer related questions.

□ Chronic Kidney Disease/End-Stage Renal Disease
- Will the member be receiving dialysis? **Yes or No** If No, answer the following questions.
  - Is the goal of using this medication to reduce the risk of alloimmunization and/or other red blood cell transfusion-related risks? **Yes or No**
  - Does the member have a rate of hemoglobin decline which would indicate the likelihood of requiring a red blood cell transfusion? **Yes or No**

□ HIV
- Is member currently receiving AZT (Zidovudine)? **Yes** or **No**
- If yes, please provide the dose that member is receiving _____

□ Cancer/Chemotherapy
- What type of cancer does the member have? _____
- What chemotherapy is the member receiving? _____
- How many month of chemotherapy are planned? _____

□ Upcoming Surgery
- Is the patient at high-risk for blood loss from surgery? **Yes or No**
- Would the drug reduce the need for an allogenic blood transfusion (from another person)? **Yes or No**
- Is the member scheduled to undergo elective, non-cardiac, non-vascular surgery? **Yes or No**

□ Hepatitis C
- Is the member being treated with ribavirin and interferon/PEG interferon? **Yes or No**

□ Rheumatoid Arthritis/Rheumatic Disease

□ Myelodysplastic syndrome
- What is the member's serum erythropoietin level in mUnits/mL? _____

□ Myeloproliferative neoplasms (myelofibrosis)
- What is the member's serum erythropoietin level in mUnits/mL? _____

□ Multiple Myeloma
- Is the member receiving chemotherapy? **Yes or No**

□ Other: _____

Clinical Values

***Please submit laboratory documentation for hemoglobin and hematocrit taken within the past 60 days.**

Current weight: _____ lbs or kg

Hemoglobin: _____g/dL Date taken: _____

Hematocrit: _____%. Date taken: _____

Transferrin Saturation: _____%

Ferritin level: _____ng/mL

Contraindication Information

Does the member have uncontrolled hypertension? **Yes or No**

Has the member had pure red cell aplasia (PRCA) that begins after treatment with an erythropoeitin protein drug such as Procrit, Epogen or Aranesp or Mircera? **Yes or No**

Is the member pregnant or nursing? **Yes or No**

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

****Complete this page ONLY for Subsequent (Renewal) requests or for dosage changes****

General Information

***Please submit laboratory documentation for hemoglobin and hematocrit taken within the past 60 days.**

Hemoglobin: _____g/dL. Date taken: _____

Hematocrit: _____%. Date taken: _____

Current Weight: _____ lbs or kg

Previous Dose: _____

New Dose: _____

Requested Quantity: _____

1. Has the member responded to this medication by having an increase in hemoglobin levels? **Yes or No**
2. Has the member responded to this medication by having a reduction in transfusions required? **Yes or No**

Please select the cause of anemia and answer related questions.

□ Chronic Kidney Disease/End-Stage Renal Disease
- Will the member be receiving dialysis? **Yes or No**

□ HIV
- Is member currently receiving AZT (Zidovudine)? Yes or No
- If yes, please provide the dose that member is receiving _____

□ Cancer/Chemotherapy
- Is the member currently receiving chemotherapy?
- If yes, what chemotherapy regimen? (Please include all the drugs and how often they are being given)
_____
- How many months of treatment with the above chemotherapy regimen are planned? _____

□ Hepatitis C
- Is the member being treated with ribavirin and interferon/PEG interferon? **Yes or No**

□ Rheumatoid Arthritis/Rheumatic Disease

□ Myleodysplastic syndrome or myeloproliferative neoplasms (myelofibrosis)

□ Multiple Myeloma

□ Other: _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**