Geisinger Health Plan

Erythropoietin Stimulating Agents (ESA) Request Form

Instructions: All areas **MUST BE COMPLETED** in order to process the request. This form must be submitted to obtain a prior authorization for an Erythropoietin Stimulating Agent (Epogen, Procrit or Aranesp). If approved, authorizations will be valid for a time period of up to 12 months. If more doses are needed, repeat prior authorizations are required. Applicable copay or coinsurance will still apply. **Please fax form to 570-214-1516.**

Patient Information ***(print legibly)***

Patient Name_____ D.O.B._____

Address _____ City_____ State _____ Zip_____

Home Phone _____Daytime Phone _____

Diagnosis _____ICD-9 code _____Health Plan Member ID #_____

Physician Information ***(print legibly)***

Physician Name _____

Office Address _____ City _____State _____Zip_____

Office Contact_____

Office Phone#_____Office Fax #_____

Physician signature and Date:

Requested Medication	Dose	Directions

Is this patient being newly initiated on ESA therapy? □ Yes □ No
How will ESA be administered? □ from provider stock at office visit □ patient will self administer with Rx dispensed
Where will ESA be administered? □ home □ provider's office □ nursing home/personal care facility
Chemotherapeutic or other relevant drug therapy including doses and most recent dates received: _____
_____
If diagnosis is anemia of chronic disease, please state the chronic disease:_____
_____
If the diagnosis is end stage renal disease, is the patient receiving dialysis? □ Yes □ No
Does the patient have symptomatic anemia? □Yes □No If yes, describe_____
_____
_____

Required labs

Hemoglobin	g/dL	**Date:**	Baseline endogenous erythropoietin level **Note:** Only required for MDS and HIV patients treated with zidovudine	MU/mL	**Date:**
Ferritin	ng/mL	**Date:**	Transferrin level saturation	%	**Date:**

Is this patient currently on iron therapy? □Yes □No
Additional information: _____
_____
_____

Note: Possession of a Health Plan insurance card does not guarantee coverage.

Geisinger Health Plan Pharmacy Department
Phone: (800) 988-4861 or Fax: (570) 214-1516

HPRX02
CURRENT EPO Request Form 12-23-16
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