ERYTHROPOIESIS STIMULATING PROTEINS PRIOR AUTHORIZATION FORM (form effective 1/1/20)


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

- For treatment of anemia associated with chronic kidney disease – INITIAL request:
  - Has irreversible kidney disease as defined by the National Kidney Foundation’s KDOQI
  - Has hemoglobin < 10 g/dL

- For treatment of anemia associated with chronic kidney disease – RENEWAL request:
  - Has an increased hemoglobin level since starting treatment with the requested medication
  - 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 patients with cancer receiving chemotherapy – INITIAL request:
  - Is currently receiving myelosuppressive chemotherapy
  - Has hemoglobin < 10 g/dL

- For treatment of anemia in patients with cancer receiving chemotherapy – RENEWAL request:
  - Has an increased hemoglobin level since starting treatment with the requested medication
  - Has a hemoglobin ≤ 12 g/dL

- For treatment of anemia in patients with HIV infection receiving zidovudine – INITIAL request:
  - Has a serum erythropoietin level ≤ 500 mU/mL
  - Is taking zidovudine at a dose of ≤ 4200 mg/week
  - Has hemoglobin < 10 g/dL

- For treatment of anemia in patients with HIV infection receiving zidovudine – RENEWAL request:
  - Has an increased hemoglobin level since starting treatment with the requested medication
  - Has a hemoglobin ≤ 12 g/dL

- For reduction of allogeneic blood transfusion in surgery patients:
  - Has hemoglobin > 10 g/dL and ≤ 13 g/dL
  - Will be undergoing elective, non-cardiac, non-vascular surgery

- For treatment of anemia caused by ribavirin in patients treated for hepatitis C virus infection – INITIAL request:
  - Has hemoglobin < 10 g/dL or is symptomatic and has hemoglobin < 11 g/dL

- For treatment of anemia caused by ribavirin in patients treated for hepatitis C virus infection – RENEWAL request:
  - Has an increased hemoglobin level since starting treatment with the requested medication
  - Has a hemoglobin ≤ 12 g/dL

Please submit to PromptPA [https://ghp.promptpa.com](https://ghp.promptpa.com) OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature: ____________________________ Date: ________________

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