Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Retacrit_Procrit_Epogen

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Has the patient been assessed for iron deficiency anemia and have found to have adequate iron stores (defined as a serum transferrin saturation [TSAT] level greater than or equal to 20% within the prior 3 months) or are they receiving iron therapy? Please attach labs/documentation.

☐ Yes ☐ No

Q2. Is the patient using the requested medication concomitantly with other erythropoiesis stimulating agents?

☐ Yes ☐ No

Q3. Is this an initial or continuation request?

☐ Initial - Go to 4 ☐ Continuation - Go to 5

Q4. Please select the indication the medication is prescribed for:

☐ Treatment of anemia due to chronic kidney disease with pretreatment hemoglobin less than 10 g/dL

☐ Treatment of anemia due to Hepatitis C treatment in patients with pretreatment hemoglobin less than 10 g/dL who are

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Retacrit_Procrit_Epogen

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

☐ Treatment of anemia due to myelosuppressive chemotherapy with nonmyeloid malignancy and pretreatment hemoglobin less than 10 g/dL

☐ Treatment of anemia in myelodysplastic syndrome in patients with pretreatment hemoglobin less than 10 g/dL whose pretreatment serum erythropoietin (EPO) level is < 500 mU/mL

☐ Reduction of allogenic red blood cell transfusion in patients scheduled to have an elective, noncardiac, nonvascular surgery with pretreatment hemoglobin less than or equal to 13 g/dL

☐ Treatment of anemia in rheumatoid arthritis in patients with pretreatment hemoglobin less than 10 g/dL

receiving ribavirin in combination with either interferon alfa or peginterferon alfa

☐ Treatment of anemia due to zidovudine in HIV-infected patients currently receiving zidovudine with pretreatment hemoglobin less than 10 g/dL whose pretreatment serum EPO level is less than 500 mU/mL

☐ Treatment of anemia in patients whose religious beliefs forbid blood transfusions with pretreatment hemoglobin less than 10 g/dL

☐ Treatment of anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis in patients who meet ALL of the following criteria:
i. Pretreatment hemoglobin less than 10 g/dL
ii. Pretreatment serum EPO level less than 500 mU/mL

☐ Treatment of anemia due to cancer in patients who have cancer and are undergoing palliative treatment.

Q5. For continuation of therapy please select the indication the medication is being requested for:

☐ Continued treatment of anemia due to chronic kidney disease with current hemoglobin less than 12 g/dL.

☐ Continued treatment of anemia due to myelosuppressive chemotherapy with nonmyeloid malignancy and current hemoglobin less than 12 g/dL.

☐ Continued treatment of anemia in myelodysplastic syndrome with current hemoglobin less than 12 g/dL

☐ Continued treatment of anemia due to zidovudine in HIV-infected patients receiving zidovudine with current hemoglobin less than 12 g/dL

☐ Continued treatment of anemia in patients whose religious beliefs forbid blood transfusions with current hemoglobin less than 12 g/dL

☐ Continued treatment of anemia in primary myelofibrosis, post-polycythemia vera

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Retacrit_Procrit_Epogen

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

☐ Continued treatment of anemia in rheumatoid arthritis with current hemoglobin less than 12 g/dL

☐ Continued treatment of anemia due to Hepatitis C treatment in patients who meet ALL of the following criteria:
i. The patient is receiving ribavirin in combination with either interferon alfa or peginterferon alfa.
ii. The current hemoglobin is less than 12 g/dL.

myelofibrosis, or post-essential thrombocythemia myelofibrosis with current hemoglobin less than 12 g/dL

☐ Continued treatment of anemia due to cancer in patients who have cancer and are undergoing palliative treatment

Q6. For continuation of therapy, is there documentation showing a response to treatment with a rise in hemoglobin of greater than 1 g/dL? Please attach labs/documentation.

☐ Yes ☐ No

Q7. Additional Information:

_____ _____

Prescriber Signature Date

v2025