Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

Complete form in its entirety and fax to 1-855-964-0556, Attn. PA pharmacist.

Contact Blue Advantage Medical Management at 1-866-508-7145 if you have questions.

PART B DRUG PRIOR AUTHORIZATION REQUEST FORM

Erythropoiesis Stimulating Agents

Erythropoiesis stimulating agents are approved for a maximum of 3 months at a time. A re-authorization request, including updated lab information, must be sent in every 3 months.

Request Type:

☐ Standard Review (72 hours)

☐ Expedited Review (24 hours) – By checking this box I certify that applying the 72-hour standard review timeframe might seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

NOTE: Missing information and lack of prompt response to requests for additional information may delay response time. Please attach relevant supporting documentation such as labs, results of diagnostic tests and office visit notes to this request.

PATIENT INFORMATION

Patient Name			DOB	
Street Address, City, State, ZIP				
Blue Advantage Member ID#	Sex ☐ M ☐ F	Weight	Height	BMI
Drug Allergies				

PRESCRIBER INFORMATION

Prescriber Name	Office Contact Person and Direct Extension
Street Address, City, State, ZIP	
Office Phone	Office Fax

DRUG DISPENSING AND ADMINISTRATION INFORMATION

Who is furnishing the drug?

- ☐ Physician's office or facility will furnish drug
- ☐ Member picking up drug at a pharmacy
  IMPORTANT NOTE: If member is picking up drug at pharmacy, this request must be faxed to the Part D drug prior authorization department at 1-877-251-5896.

Facility Where Drug is to be Administered

- ☐ Physician's Office
- ☐ Outpatient Infusion Center
  Center Name: _____
- ☐ Home Infusion
  Agency Name: _____

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

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MEDICATION	
☐ Aranesp ☐ Epogen ☐ Procrit ☐ Mircera Dose, route, frequency: _____ ☐ New start ☐ Continued treatment	Next treatment date:

DIAGNOSIS (select one)	
☐ Anemia associated with Chronic Kidney Disease (<u>not</u> on dialysis) ☐ Anemia associated with ESRD (on dialysis) ☐ Anemia secondary to myelosuppressive chemotherapy ☐ Anemia associated with Myelodysplastic Syndrome (MDS)	☐ Reduction of allogeneic RBC transfusions in patients undergoing elective, noncardiac, nonvascular surgery ☐ Anemia in Zidovudine treated HIV-infected patients ☐ Anemia of Chronic Disease *(please specify the chronic condition diagnosis)*

MEDICAL INFORMATION The submitted hemoglobin level must be drawn within **30 days** of request for anemia due to CKD or anemia of chronic disease, and within **7 days** of request for anemia due to myelodysplastic syndrome or myelosuppressive chemotherapy.

Hemoglobin and/or hematocrit	Result	Date
Iron saturation (transferrin saturation)	Result	Date
Ferritin	Result	Date
Vitamin B12	Result	Date
Folate	Result	Date
Creatinine clearance or glomerular filtration rate	Result	Date
Pre-treatment erythropoietin level *(needed for myelodysplastic syndrome and anemia of chronic disease indications only)*	Result	Date
Bone marrow biopsy % blast count *(needed for myelodysplastic syndrome indication only)*	Result	Date

Patient is experiencing the following symptoms related to anemia:

☐ fatigue ☐ shortness of breath ☐ lightheadedness ☐ weakness
☐ tachycardia ☐ angina ☐ inability to perform activities of daily living

Iron supplementation is required if the serum ferritin is less than 100 mcg/L or iron saturation is less than 20%. Is the patient receiving parenteral or oral iron therapy?

☐ Yes ☐ No

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Has the patient required a transfusion? ☐ Yes Date of most recent: _____ ☐ No
Is the patient receiving Vitamin B12 supplementation if deficient? ☐ Yes ☐ No
Is the patient receiving Folate supplementation if deficient? ☐ Yes ☐ No
Feel free to provide additional information you feel is relevant to the request below:

Prescriber Signature	Date

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