

REQUIRED DOCUMENTATION FOR APPROVAL OF MONTHLY ERYTHROPOIETIN (EPOGEN[®]) DOSES GREATER THAN 50,000 UNITS

Fax to Pharmacy Services at **855-811-9332**, or call **888-602-3741** to speak to a representative. **Form must be completed for processing**



Patient Name: _____	Patient ID #: _____
Address: _____	Apt # or Suite #: _____
City: _____ State: _____	Zip Code: _____
Phone #: _____	Birth Date: _____
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Physician Name: _____	NPI #: _____
Address: _____	Apt # or Suite #: _____
City: _____ State: _____	Zip Code: _____
Contact Person: _____ Phone #: _____	Fax #: _____
Physician Signature: _____	Date: _____

The following lab reports and specific requested documentation needs to be provided for authorization for cumulative monthly Erythropoietin doses greater than 50,000 units.

1. Is the therapy (please check one): **Naive Therapy** **Continuation of Therapy**

2. **Dosage:** Epogen _____ Units Sig: _____
****Note:** Doses greater than 300 units/kg/week require documentation that rules out possible causes for Erythropoietin resistance and a Hematologist consult/recommendation for doses greater than 300 units/kg/week.**

3. Current Dry Weight: _____ kg or _____ lbs. Current Iron Supplement regimen _____

4. Hemoglobin/Hematocrit (Hgb/Hct) and Red Cell indices – require results that are within 30 days of the date of the request and if available, results for the last 3 months in order to determine a rolling average.

5. Serum Iron, Total Iron Binding Capacity (TIBC), Vitamin B12 and Folate levels – require results that are within 60 days of the date of the request.

6. Ferritin and transferrin saturation results - require results that are within 30 days of the date of the request and if available results for the past 3 months.

7. Recent (within 60 days of submitted request) Vitamin B12 Level: _____, Date: _____, Folate Level: _____, Date: _____ or attach lab results with request

8. If the member has been receiving Erythropoietin please indicate the current and weekly doses of erythropoietin for the past 2 months:

