



Retacrit

**Express Scripts
Prior Authorization
Phone 1-844-424-8886
Fax 1-877-251-5896**

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week, TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: medicarepartdparequests@express-scripts.com

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:
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This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

SECTION A Please answer the following questions

1. Yes No Will the requested drug be used in an End Stage Renal Disease (ESRD) patient who is receiving renal dialysis services??
2. Does the patient have any of the following contraindications to Procrit use?
 - Uncontrolled hypertension
 - Pure red cell aplasia (PRCA) that occurred after prior treatment with erythropoiesis-stimulating agents (e.g., epoetin alfa, etc.)
 - None of the above
3. Will the requested drug be used for any of the following indications that are not FDA-approved?
 - In patients with cancer receiving hormonal agents, biologic products, or radiotherapy and who are not receiving concomitant myelosuppressive chemotherapy
 - In patients scheduled for surgery who are willing to donate autologous blood
 - In patients undergoing cardiac or vascular surgery
 - As a substitute for RBC (red blood cells) transfusions in patients who require immediate correction of anemia
 - None of the above

4. Yes No Is the patient iron, folate, or vitamin B12 deficient? *(If No, skip question 5.)*
5. Yes No Is the patient currently being treated for iron, folate, or vitamin B12 deficiency?
6. Yes No Does the patient have a pretreatment serum ferritin greater than or equal to 100mcg/L and serum transferrin saturation greater than or equal to 20%?
7. Yes No Have other causes of anemia (e.g., hemolysis, bleeding, etc.) been ruled out?
8. Yes No Is the diagnosis or indication for the treatment of anemia associated with chronic kidney disease? *(If No, skip to question 10.)*
9. Yes No Is the patient's pretreatment hemoglobin level less than 10g/dL or pretreatment hematocrit less than 30%?
10. Yes No Is the diagnosis or indication for the reduction of allogeneic blood transfusion in patients with non-myeloid malignancies receiving concomitant myelosuppressive chemotherapy? *(If No, skip to question 13.)*
11. Yes No Is the patient's pretreatment hemoglobin level less than 10g/dL or pretreatment hematocrit less than 30%?
12. What is the planned length of treatment with chemotherapy?
Please document the planned length of treatment with chemotherapy:

13. Yes No Is the diagnosis or indication for the reduction of allogeneic blood transfusion in anemic patients scheduled to undergo elective noncardiac, nonvascular surgery? *(If No, skip to question 16.)*
14. Yes No Is antithrombotic DVT prophylaxis considered?
15. Yes No Is the patient's perioperative hemoglobin greater than 10g/dL and less than or equal to 13g/dL?
16. Yes No Is the diagnosis or indication for the treatment of anemia related to zidovudine-treatment in HIV-infected patients? *(If No, skip to question 18.)*
17. Yes No Is the pretreatment endogenous serum erythropoietin level less than 500 microunits/mL?
18. Yes No Is the diagnosis or indication for the treatment of anemia in low or intermediate-1 risk Myelodysplastic Syndrome (MDS) patients?
19. Yes No Is the patient transfusion-dependent?
20. Yes No Is the patient symptomatic from anemia?
21. Yes No Is the pretreatment endogenous serum erythropoietin level less than 500 milliunits/mL?

Please document the symptoms and/or any other information important to this review:

PHYSICIAN SIGNATURE_____
DATE**FAX COMPLETED FORM TO: 1-877-251-5896**

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at <http://www.villagehealthca.com>