Neighborhood Health Plan OF RHODE ISLAND™

Epogen/Procrit Authorization form
J0885

Tel. 401-427-8200; Fax 844-639-7906

Epogen/Procrit Prior Authorization form (Drugs Administered in Office), fax requests to 844-639-7906

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
Member Phone Number:	Member Address:	Gender: □ Male □Female □Unknown Primary Language: □ English □Spanish □ Other:
REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Date of Request:	Provider's NPI #:	Provider's Contact Name and Phone:

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

❑ Drop Ship from Specialty Pharmacy: _____and NPI_____

❑ If Buy & Bill: Specify Provider/ Facility: _____ and NPI _____

Servicing Provider Fax#: _____

CLINICAL INFORMATION		
Requested J-Code:	Requested CPT code(s):	□ Initial Request □ Continuation of therapy Request
Drug Name& strength:		Date(s) of Service Requested:
Directions:		# of units:
ICD 10 Codes:		

Clinical Assessment (provide all required information and clinical documentation)	YES	NO
Is the patient is being treated for chemotherapy-induced anemia AND:	☐	☐
a. Patient has a hemoglobin level less than 10 g/dL; and	☐	☐
b. Patient has a minimum of two additional months of planned chemotherapy	☐	☐
Is the patient being treated for anemia related to chronic kidney failure; AND:	☐	☐
a. Patient is not diagnosed with end-stage renal disease and currently on dialysis; and	☐	☐
b. Patient's laboratory results (within 30 days of request) support all of the following:		
• Transferrin saturation level above 20%, and	☐	☐
• Ferritin level greater than 100 ng/mL; and	☐	☐
• Hemoglobin less than 10 g/dL for initial or hemoglobin less than or equal to 11 g/dL for renewal;	☐	☐

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Is the patient being treated for anemia related to HIV therapy with zidovidine; AND a. Patient is taking less than 4200 mg of zidovudine per week; and b. Laboratory results (within 30 days of request) support all of the following: i. Endogenous serum erythropoietin level less than 500 mUnits/mL; and ii. Hemoglobin level less than 12 g/dL;	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Is the patient at risk for requiring an allogenic blood transfusion due to elective surgery; AND have laboratory results (within 30 days of request) with Hemoglobin levels between 10 and 13 g/dL?	☐	☐
Does the Patient have any of the following: a. Patient diagnosed with end-stage renal disease and currently on dialysis; b. Patients that have an anticipated outcome of cure; c. Patients with uncontrolled hypertension; d. Patients with pure red cell aplasia (PRCA) that develops after treatment with any erythropoietin drug; e. Diagnosis being treated is not FDA-approved or a recognized indication.	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
NOTE(S): Epogen is covered under the Medical Benefit as part of the ESRD bundle for members diagnosed with end-stage renal disease currently on dialysis. Epogen or any other Erythropoietin are not covered separately for these members.		
NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN		

Signature of Requesting Provider:	Date:

Authorization is not a guarantee of payment. Member must be eligible at time of service.

Neighborhood Health Plan of Rhode Island Tel. 401-427-8200 Fax at 844-639-7906