BlueCross BlueShield
Federal Employee Program

# EPOGEN/PROCRIT
# PRIOR APPROVAL REQUEST

**Send completed form to:**
**Blue Shield of California**
**Fax:1-855-895-3504**

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

## CARDHOLDER COMPLETES

Date: ____/ ____/ ____

Cardholder Name: _____ / _____ / _____
First MI Last

Patient Name: _____ / _____ / _____
First MI Last

Patient Address: _____
Street

_____
City State Zip

Patient Date of Birth: ____/ ____/ ____ Sex: M ____ F ____ **R** [ ]
Cardholder Identification Number

## PHYSICIAN COMPLETES

**Please select one: ❑ EPOGEN ❑ PROCRIT**

NOTE: Form must be completed in its **entirety** for processing

What is the **diagnosis** for which this drug is being prescribed? **(Please answer all corresponding questions below diagnosis)**

❑ Anemia secondary to Chronic Renal Failure. ***Note: Approval cannot be given unless all lab values are provided.**
- What type of treatment regimen is being requested? ❑Initial treatment ❑Continuation of treatment
- Is the patient on dialysis? ❑Yes ❑No
- *What is the patient's **Hemoglobin**? _____ g/dl
- *What is the patient's **Serum Ferritin**? _____ ng/ml
- Will the patient's dose be held or reduced if the hemoglobin level exceeds the requirements below**? ❑Yes ❑No
- **Non Dialysis patients**: must be < 10g/dl for initial treatment or ≤ 10g/dl for continuation of treatment
- **Dialysis patients**: must be < 10g/dl for initial treatment or ≤ 11g/dl for continuation of treatment

❑ Anemia secondary to chemotherapy:
- Is patient receiving concomitant myelosuppresive therapy? ❑Yes ❑No
- Is the anticipated outcome CURE of cancer? ❑Yes ❑No
- Is there a minimum of two additional months of chemotherapy planned? ❑Yes ❑No
- Will use of agent be discontinued upon completion of the chemotherapy? ❑ Yes ❑ No

❑ Anemia associated with Hepatitis C (HVC) treatment

❑ Anemia secondary to zidovudine therapy:
- Does the patient have documentation of HIV infection? ❑Yes ❑No

❑ Anemia scheduled to undergo elective, non-cardiac, nonvascular surgery: ***Note: Approval cannot be given unless Hg provided.**
- *What is the patient's **Hemoglobin**? _____g/dl

❑ Anemia associated with rheumatoid arthritis (RA)/rheumatic disease

❑ Allogenic bone marrow transplantation

❑ Myelodysplastic syndrome

❑ Other Diagnosis _____

The information provided on this form will be used to determine the provision of health care benefits under a U.S. federal government program, and any falsification of records may subject provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification.

**Prescriber Certification:**I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer

| Physician Name (Print Clearly) | (____) Phone | (____) Fax |
|---|---|---|
| Street Address | City | State / Zip |
| Physician's NPI | Physician Signature | ____/____/____ Date |

EPOGEN/PROCRIT– CSU
Revised 4/4/2014