

Bravo Health

Coverage Review / Prior Authorization Request Form

Epoetin alfa injection (Epogen®, Procrit®)

Darbepoetin alfa injection (Aranesp®)



| Patient Information | | Prescriber Information | |
|---|-----------|-------------------------|--|
| Member Name: | | Prescriber Name: | |
| Bravo ID # | | Prescriber Specialty: | |
| DOB: | | Prescriber Address: | |
| Address: | | | |
| | | Office Phone#: | |
| Home Phone: | | Office Fax #: | |
| | | Contact Person: | |
| Diagnosis and Medication Requested | | | |
| Medication Requested (dosage, frequency): | | Qty: | |
| Prescribing Diagnosis: | ICD9 Code | Date Therapy Initiated: | |
| Clinical Criteria | | | |
| Please answer the following questions: | | | |
| Administration: | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No EPO will be administered in renal dialysis facility, clinic, or physician office OR | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No EPO will be self-administered in the home by the patient (or caregiver) OR | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No EPO will be administered in the LTC where member resides | | | |
| Laboratory Documentation: | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Laboratory Data with current hemoglobin and hematocrit is attached | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Laboratory Data with patient's erythropoietin level is attached (For HIV or Myelodysplasia) | | | |
| Clinical Information: | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has ESRD AND is on dialysis | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has anemia associated with chronic renal insufficiency | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment of anemia secondary to myelosuppressive chemotherapy | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment of anemia secondary to HIV infection or HIV drug therapy | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment of anemia secondary to Myelodysplasia | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment of anemia associated with CHC treatment from ribavirin and interferon therapy | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Reduction of allogeneic blood transfusion in surgery patients | | | |
| **Laboratory Data must be provided. Failure to provide adequate data could result in denial of this request. Laboratory Data must be dated less than 14 days. | | | |
| Additional Comments/Explanation: | | | |
| Request for Expedited Review | | | |
| REQUEST FOR EXPEDITED REVIEW [24 HOURS] | | | |
| <input type="checkbox"/> BY CHECKING THIS BOX AND SIGNING BELOW, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION | | | |

Prescriber's Signature:

Date:

Fax back to: 866-464-0709 For info call: 877-813-5595
For additional Prior Authorization forms, go to <http://www.bravohealth.com/providers.aspx>