

Member Name: _____ Member ID: _____ Member DOB: _____
Drug Name: _____ Strength: _____ Directions: _____
Physician Name: _____ Physician Phone #: _____ Specialty: _____
Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Epoetin Alfa and Darbepoetin Alfa – Medical Necessity Request

****Please complete page 1 for New/Initial Requests****

1. Does the member have Anemia? **Yes or No**
- If no, what is the drug being used for? _____
2. Have other causes of anemia been excluded (e.g. GI bleeding, iron or folate deficiency, hemolysis)? **Yes or No**
3. Is the member currently on iron therapy? **Yes or No**
4. Does the member have sickle cell disease? **Yes or No**

Please select the cause of anemia and answer related questions.

- Chronic Kidney Disease/End-Stage Renal Disease
 - Will the member be receiving dialysis? **Yes or No** If No, answer the following questions.
 - Is the goal of using this medication to reduce the risk of alloimmunization and/or other red blood cell transfusion-related risks? **Yes or No**
 - Does the member have a rate of hemoglobin decline which would indicate the likelihood of requiring a red blood cell transfusion? **Yes or No**
- HIV
 - Is member currently receiving AZT (Zidovudine)? **Yes or No**
 - If yes, please provide the dose that member is receiving _____
- Cancer/Chemotherapy
 - What type of cancer does the member have? _____
 - What chemotherapy is the member receiving? _____
 - How many month of chemotherapy are planned? _____
- Upcoming Surgery
 - Is the patient at high-risk for blood loss from surgery? **Yes or No**
 - Would the drug reduce the need for an allogenic blood transfusion (from another person)? **Yes or No**
 - Is the member scheduled to undergo elective, non-cardiac, non-vascular surgery? **Yes or No**
- Hepatitis C
 - Is the member being treated with ribavirin and interferon/PEG interferon? **Yes or No**
- Rheumatoid Arthritis/Rheumatic Disease
- Myelodysplastic syndrome
- Bone Marrow Transplant
 - Has the member had an allogenic bone marrow transplant (from another person)? **Yes or No**
- Other: _____

Clinical Values

***Please submit laboratory documentation for hemoglobin and hematocrit taken within the past 60 days.**

Current weight: _____ lbs or kg
Hemoglobin: _____ g/dL Date taken: _____
Hematocrit: _____%. Date taken: _____
Transferrin Saturation: _____%
Ferritin level: _____ ng/mL

Contraindication Information

Does the member have uncontrolled hypertension? **Yes or No**
Has the member had pure red cell aplasia (PRCA) that begins after treatment with an erythropoietin protein drug such as Procrit, Epogen or Aranesp or Mircera? **Yes or No**
Is the member pregnant or nursing? **Yes or No**

Physician office's signature* _____ Print Name _____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____
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****Complete this page ONLY for Subsequent (Renewal) requests or for dosage changes****

<p style="text-align: center;">General Information</p> <p>*Please submit laboratory documentation for hemoglobin and hematocrit taken within the past 60 days.</p> <p>Hemoglobin: _____ g/dL. Date taken: _____</p> <p>Hematocrit: _____ %. Date taken: _____</p> <p>Current Weight: _____ lbs or kg</p> <p>Previous Dose: _____</p> <p>New Dose: _____</p> <p>Requested Quantity: _____</p>
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1. Has the member responded to this medication by having an increase in hemoglobin levels? **Yes or No**
2. Has the member responded to this medication by having a reduction in transfusions required? **Yes or No**

Please select the cause of anemia and answer related questions.

- Chronic Kidney Disease/End-Stage Renal Disease
 - Will the member be receiving dialysis? **Yes or No**
- HIV
 - Is member currently receiving AZT (Zidovudine)? Yes or No
 - If yes, please provide the dose that member is receiving _____
- Cancer/Chemotherapy
 - Is the member currently receiving chemotherapy?
 - If yes, what chemotherapy regimen? (Please include all the drugs and how often they are being given) _____
 - How many months of treatment with the above chemotherapy regimen are planned? _____
- Hepatitis C
 - Is the member being treated with ribavirin and interferon/PEG interferon? **Yes or No**
- Rheumatoid Arthritis/Rheumatic Disease
- Myelodysplastic syndrome
- Bone Marrow Transplant
- Other: _____

Physician office's signature* _____ Print Name _____

*Form must be completed and signed by physician or licensed representative from the physician's office