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P.O. Box 98031 • Baton Rouge, Louisiana • 70898-9031

CONFIDENTIAL
PATIENT INFORMATION

DRUG AUTHORIZATION FORM
Erythropoietin Stimulating Agents

Phone: 800-842-2015 Fax: 877-837-5922

PATIENT DATA	Last Name	First Name	Policy Number	Date of Birth	Age
REQUESTING PHYSICIAN DATA	Last Name	First Name	Contact Name	Fax Number ( )	
BCBSLA Provider Number	Area of Practice/Specialty	Name of Place of Treatment	Treatment Center Provider #	Phone Number ( )	
BILLING DATA	Diagnosis Code(s) (ICD-9): 1) 2)	CPT-4/HCPCS Code	Other Codes		

DRUG INFORMATION

☐ **Initial Request** (new start/not currently on ESAs)
☐ **Extension Request** (currently on ESA therapy)

☐ Yes ☐ No Has patient failed Epo or Procrit (**Aranesp requests for anemia in cancer patients only)?**
☐ List start date for extension requests ____________________

☐ ARANESP®	☐ EPOGEN® ☐ PROCRIT®	☐ OTHER __________________	Dosage and Frequency: ________________________	Anticipated Start Date

INDICATION / DIAGNOSIS

☐ Chronic Kidney Disease (CKD)/Chronic Renal Failure
☐ End Stage Renal Disease (ESRD)
☐ Metastatic non-myeloid malignancy
☐ Myelodysplastic syndrome
☐ Hepatitis C
☐ Pre-op elective surgery (non-cardiac, non-vascular)
☐ HIV (on AZT)
☐ Critically ill in hospital ICU
☐ Other Indication(s) __________________________

LAB DATA

Initial Lab Data		**Follow-up Lab Data**	
Hgb Level__________(g/dL)	Test Date__________	Hgb Level__________(g/dL)	Test Date_________
Hct Level__________(%)	Test Date__________	Hct Level__________(%)	Test Date_________
Transferrin Saturation__________%	Test Date__________	Transferrin Saturation__________%	Test Date_________
Ferritin Level__________(ng/ml)	Test Date__________	Ferritin Level__________(ng/ml)	Test Date_________

OTHER CLINICAL INFORMATION (Check ALL that apply)

☐ Yes ☐ No **Black Box Warning for Cancer Diagnosis:** Are there any contraindications to the current FDA labeling for Procrit?
Chemotherapy: ***End date of current cycle*** ?____/____/____ If not on chemo, ***end date of previous cycle***? ____/____/____
Surgery: If requesting administration prior to elective surgery, what is the expected surgery date? ____/____/____
****Off Label and HIV on AZT:** Submit chart documentation indicating rationale for therapy and supportive lab values.
☐ Yes ☐ No Will the patient be receiving the drug in the physician's office? If no, **list name** of servicing provider.
____

IRON SUPPLEMENT THERAPY

☐ Yes ☐ No Is the patient currently receiving iron supplement therapy? If yes, list drug name and dosage:_____________________
☐ Yes ☐ No Will physician follow FDA/ASCO guidelines for administering iron supplement therapy?

EXTENSION REQUESTS ***(Complete this section for extensions only – Include follow-up lab values above)***
What is the duration (time frame) of additional therapy requested: __________________(months)
What ***was*** the initial ***starting dose*** and frequency? ____Initial Start Date ____/____/____
What ***is the current dose*** and frequency (***if different from requested dose***)? _______________________Initial Start Date ____/____/____

PHYSICIAN SIGNATURE ____ **Prescribing Physician**	**DATE** ________________________________

Note: On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. We recommend you contact BCBSLA at 800-922-8866 to verify benefits. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

Incomplete forms will not be processed