Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Retacrit (epoetin alfa-epbx) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 weeks; Continuation- 12 weeks

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Retacrit (epoetin alfa-epbx).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the prescriber a nephrologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Member has contraindication, intolerance or failure to preferred epoetin alfa product (i.e., Procrit), **AND**
   □ No □ Yes

2. Member has a diagnosis of one of the following:
   - ESRD or chronic kidney disease of at least stage 3 (eGFR <60mL/min/1.73 m2)
   - Chemotherapy-induced anemia in non-myeloid malignancies
   - Cancer patients who are undergoing palliative treatment
   - Myelodysplastic syndrome (MDS)
   - Anemia in patients whose religious beliefs forbid blood transfusions
   - Reduction of allogenic red blood cell transfusion in patients undergoing elective, noncardiac, nonvascular surgery
   - Chronic Hepatitis C
   - Anemia Due to Zidovudine in HIV-infected patients
   - Patient taking chemotherapeutic medications when medically necessary for non-cancer diagnosis or following stem cell transplantation and associated immunosuppression

   □ No □ Yes
   AND

3. Hemoglobin <10 g/dL within 7 days (unless medical documentation showing need – e.g., severe angina, severe pulmonary distress, severe hypertension) **AND**
   □ No □ Yes

4. TSAT ≥20% unless ferritin >500, then may be approved with TSAT <20%, **AND**
   □ No □ Yes

5. B12 and folate NOT deficient, **AND**
   □ No □ Yes

6. Member does not have uncontrolled hypertension, **AND**
   □ No □ Yes

7. Member is not using in combination with another erythropoiesis stimulating agent
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Target hemoglobin <12 g/dL within 7 days **AND**
   □ No □ Yes

2. Clinical response to ESA therapy – increase in HGB of at least 1g/dL after at least 12 weeks of therapy
   □ No □ Yes

7 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**

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