Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Mircera (methoxy polyethylene glycol-epoetin beta) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation-6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Mircera (methoxy polyethylene glycol-epoetin beta).** 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 anemia associated with chronic kidney disease **AND**
   □ No □ Yes

3. Serum ferritin ≥100 ng/mL AND
   □ No □ Yes

4. NOT used in combination with another erythropoiesis stimulating agent **AND**
   □ No □ Yes

5. NOT used for anemia due to cancer chemotherapy **AND**
   □ No □ Yes

6. One of the following:
   - If patient is NOT on dialysis, hemoglobin <10 g/dL (initial treatment); hemoglobin ≤10 g/dL*(continuing treatment)
   - If patient is on dialysis, hemoglobin <10 g/dL (initial treatment); hemoglobin ≤11 g/dL* (continuing treatment)

   *If the hemoglobin level exceeds this level then the prescribing physician must confirm that the dose will be held or reduced until the hemoglobin level returns to the required level.
   □ No □ Yes

For continuation of therapy, please respond to additional questions below:

1. The member continues to meet initial coverage criteria
   No □ Yes

2. Member shows 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:**

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

Provider Signature:	**Date:**

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