

Physician Request Form for **PROCRT**

Fax non-urgent requests to PerformRx Pharmacy Services at **866-369-6041** or urgent requests to **866-533-5497**. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **866-369-6037**. **Form must be completed for processing.**



Patient Name: _____
Address: _____
City: _____ State: _____
Phone #: _____

Plan ID#: _____
Apt # or Suite #: _____
Zip Code: _____
Birthdate: _____

Physician Name: _____
Address: _____
City: _____ State: _____
Contact Person: _____ Phone #: _____

NPI #: _____
Apt # or Suite #: _____
Zip Code: _____
Fax #: _____

Physician Signature: _____

Deliver to Patient's Home Deliver to Physician's Office Pick-up at Local Pharmacy (Name/Phone#): _____

Is the member/patient currently residing in a Long-Term Care (LTC) facility? (please check) Yes No

Naive Therapy Continuation of Therapy Patient weight: _____ lbs or _____ kg

To be Administered From: _____ to _____ OR on: _____

Is the patient on concurrent iron therapy? (please check) Yes No If yes, indicate iron regimen: _____

Is the patient on folate and/or vitamin B12 therapy? (please check) Yes No If yes, indicate regimen: _____

(Virtually all patients will eventually require supplemental iron therapy to increase/maintain transferrin saturation to levels which will adequately support erythropoiesis stimulated by Procrit - TSAT>20% and Ferritin >100 ng/mL required to avoid functional iron deficiency)

Labs (Please submit a copy of the most recent labs and/or complete the following - lab values should be within 30 days of request)

Hb: _____ g/dL Hct: _____ % Date of labs: _____

GFR _____ ml/min/1.73m² Has the patient met the criteria for CKD (as defined by KDOQI) for ≥ 3 months? (please check) Yes No

TSAT: _____ % (TSAT>20% and Ferritin >100 required to avoid functional iron deficiency) Ferritin: _____ ng/mL Date of labs: _____

Vitamin B12 level: _____ Date: _____, Folic Acid Level: _____ Date: _____

(If baseline B12 and Folic acid levels are within normal limits, repeat levels not necessary for reauthorization)

Diagnosis (please check the appropriate diagnosis box and fill out the requested information)

ANEMIA DUE TO HIV RELATED CAUSES - Recommended starting dose=100 U/kg three times a week

Is the Patient receiving AZT (Retrovir® Zidovudine) therapy? {Circle one} YES NO

ANEMIA DUE TO CHEMOTHERAPY - Recommended starting dose=150 U/kg three times a week or 40,000 units once per week

NOTE: All patients must be advised of the benefits/risks of ESA treatment and must receive the Procrit Medication Guide. ESAs are not indication for patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure.

Is the Patient currently receiving chemotherapy? {Circle one} YES NO

Please Specify Chemotherapy Regimen and Date(s) of treatment: _____

Administering Procrit in smaller doses two or three times a week (i.e. 10,000 Units three times a week) is as effective as administering a higher, once weekly dose (i.e. 40,000 Units weekly) and has the advantage of administering less drug.

Rx for Chemotherapy OR HIV Anemia: Procrit _____ Units Sig: _____

Requested Duration: _____

ANEMIA DUE TO CHRONIC RENAL FAILURE
• Recommended starting dose=80-120 U/kg weekly (typically 6,000 U/week)

Rx Procrit _____ Units Sig: _____

Requested Duration: _____

ANEMIA DUE TO OTHER CAUSES

Diagnosis: _____

Rx Procrit _____ Units

Sig: _____

Requested Duration: _____

Medical Reason for Prescribing Procrit instead of Aranesp: _____