Health New England
Medication Request Form (MRF)/Prescription Request
Procrit® (epoetin alfa), Epogen® (epoetin alfa), and Aranesp® (darbepoetin alfa)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY	**Prior Authorization**	DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:	☐ **Prior Authorization Only**	Approved:
Physician:	☐ **Prior Authorization and Drug Delivery Request**	Quantity approved:
Pharmacy:		PA from and thru date:
Patient:		PA #
		Denied:
		Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Procrit®, Epogen®, or Aranesp®. Please complete this form and fax to ICORE Healthcare at **(866) 364-2673**. If you have any questions regarding this process, please contact ICORE Healthcare at **(800) 775-5138**.

Medication Request Information (please complete each section of this form prior to transmittal):

J-code: Epogen/Procrit: per 1000 units: J0885 (non-ESRD): J0886 (ESRD)
Aranesp: per 1mcg: J0881 (non-ESRD): J0882 (ESRD)

Patient Information (all required)	**Physician Information (all required)**
Patient Name:	**Physician Name:** **Specialty:**
Patient Cell Phone #: ( ) -	**NPI#:**
Patient HNE ID#:	**HNE Provider #:**
Patient Date of Birth:	**DEA #:**
Allergies:	**Telephone # : ( ) -**
	Fax #: ( ) -

Drug Information

Note**:** per new FDA warnings, start with lowest dose & gradually increase to lowest level to avoid transfusions. Hemoglobin should not rise by greater than 1gm per dl every2 weeks. *Target hemoglobin should be 11-12. HNE will not approve for hemoglobin greater than 12.*

Requested Drug/Strength/Form: ☐ **Procrit** ☐ **Epogen** ☐ **Aranesp**	
Dose, Directions, and length of treatment (please be specific	☐ **Initial Request (patient has never been on before)** ☐ **Renewal Request**
Quantity (per month):	**Refills:**
Physician Signature:	**Date:**

Please check or fill in all sections:

1. Please indicate patient's diagnosis: (usual starting doses for Epoetin are listed. Aranesp: Epoetin is 1:260)
   - ☐ Anemia associated with chronic renal failure.
   - ☐ Anemia in cancer patients on chemotherapy AND patient has a non-myeloid malignancy.
   - ☐ Myelodysplastic syndrome with erythropoietin level <500 mU/ml
   - ☐ Anemia associated with zidovudine (AZT) therapy in HIV-infection and AZT dose is less than or equal to 4,200mg/week.
   - ☐ Anemia associated with ribavirin therapy in a patient with chronic hepatitis C.
   - ☐ Reduction of allogenic blood transfusion in surgery patients
   - ☐ Other (specify). _____
2. Please provide most recent laboratory evidence:
   - Hemoglobin-Hb-(g per dl) (required) _____
   - Erythropoietin level _____
   - Transferrin saturation (%) _____ OR
   - Serum ferritin (ng per ml) _____
   - Folic acid deficiency has been ruled out (please circle) Yes No
   - Vitamin B-12 deficiency has been ruled out (please circle) Yes No