HIGHMARK HEALTH OPTIONS

Updated: 09/2024
Approved: 09/2024

Request for Prior Authorization for Erythropoiesis Stimulating Agents
Website Form www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030

All requests for Erythropoiesis Stimulating Agents require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Erythropoiesis Stimulating Agents Prior Authorization Criteria:

ESAs include Aranesp (darbepoetin alfa), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx), Mircera (methoxy polyethylene glycol-epoetin beta). New products with this classification will require the same documentation.

For oncology requests:

- **Duration of Approval:** 6 months

For non-oncology requests for ESAs the following criteria must be met in addition to the diagnosis specific requirements below:

- Member has been evaluated for other causes of anemia (e.g., vitamin deficiency, bleeding, metabolic or chronic inflammatory conditions, etc.).
- Member's iron status has been evaluated prior to and during erythropoietin therapy. Transferrin saturation (TSAT) should be >20% and serum ferritin >100 ng/mL or the member should be on concurrent iron therapy.
- If hemoglobin exceeds a threshold listed below, prescriber must indicate erythropoietin will be held or titrated downward.
- Lab results (e.g., hemoglobin) must be from within 30 days of the request.
- Must be used for an FDA-approved or medically accepted indication
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided for **anemia of chronic renal disease** when the following criteria is met:

- Hemoglobin < 10 g/dL or hematocrit< 30%
- **Initial Duration of Approval:** 3 months
- **Reauthorization Criteria:**
  - hemoglobin ≤ 12 g/dL or hematocrit < 36%
  - Must be on concurrent iron therapy unless both the transferrin saturation (TSAT) ≥20% and serum ferritin ≥100 ng/mL
- **Reauthorization Duration of Approval:** 6 months

Coverage may be provided for **anemia due to treatment with zidovudine in HIV** when the following criteria is met:

- Hemoglobin < 10 g/dL or hematocrit< 30%
- Member has a serum erythropoietin level ≤ 500 mUnits/mL

- Member is receiving a dose of zidovudine ≤ 4200 mg/week
- **Initial Duration of Approval:** 3 months
- **Reauthorization Criteria:**
  - Hemoglobin ≤ 12 g/dL or hematocrit <36%
  - Must be on concurrent iron therapy unless both the transferrin saturation (TSAT) ≥20% and serum ferritin ≥100 ng/mL
- **Reauthorization Duration of Approval:** 6 months

Coverage may be provided **to reduce the need for allogeneic blood transfusions in surgery patients** when the following criteria is met:

- Member is scheduled to undergo elective, noncardiac, nonvascular surgery
- Hemoglobin must be >10 g/dL and ≤ 13 g/dL
- **Initial Duration of Approval:** 1 month
- **Reauthorization Criteria:**
  - Provided on a case by case basis, refer to initial criteria for reauthorization
- **Reauthorization Duration of Approval:** 1 month

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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ERYTHROPOETIN STIMULATING AGENTS PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE: _____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Is this being used for supportive therapy for an oncology diagnosis? ☐ Yes ☐ No

For non-oncology use:

Has the member been evaluated for other causes of anemia? ☐ Yes ☐ No

Is the member currently receiving iron supplementation? ☐ Yes ☐ No

If no, provide serum ferritin: _____ng/mL Transferrin saturation (TSAT): _____ % Date of test: _____

What is the member's current hemoglobin level (within 30 days of the request) (g/dL): _____ Date: _____

What is the member's current hematocrit level % (within 30 days of request): _____ Date: _____

Will erythropoietin be held or titrated downward if hemoglobin exceeds the recommended goal? ☐ Yes ☐ No

Has the member required RBC transfusions? ☐ Yes, please describe: _____ ☐ No

For anemia due to treatment with zidovudine in HIV:

- Erythropoietin Level: _____mUnits/mL Date drawn: _____
- Weekly zidovudine dose: _____mg/week

As therapy to reduce the need for allogeneic blood transfusions

- Is the member scheduled to undergo elective, noncardiac, nonvascular surgery? ☐ Yes, date: _____ ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date