Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Erythropoiesis Stimulating Proteins

A. Prescriptions That Require Prior Authorization

All prescriptions for preferred and non-preferred Erythropoiesis Stimulating Proteins must be prior authorized. See Preferred Drug List (PDL) for the list of preferred Erythropoiesis Stimulating Proteins at: https://papdl.com/preferred-drug-list.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for preferred and non-preferred Erythropoiesis Stimulating Proteins, the physician reviewer's determination of whether the requested prescription is medically necessary will take into account the following:

1. For all non-preferred Erythropoiesis Stimulating Proteins, whether the recipient has a documented history of therapeutic failure, contraindication or intolerance of the preferred Erythropoiesis Stimulating Proteins; **AND**

2. For a diagnosis of anemia associated with chronic kidney disease, whether the recipient:

    a. Has irreversible chronic kidney disease as defined by the National Kidney Foundation's (NKF) Kidney Disease Outcome Quality Initiative (KDOQI); **AND**
    b. Has Hemoglobin < 10 g/dL; **AND**
    c. Has transferrin or iron saturation ≥ 20% and ferritin ≥ 100ng/ml; **AND**
    d. Has an evaluation of vitamin B12 and folate levels with therapeutic supplementation as indicated; **AND**
    e. Has adequately controlled blood pressure; **AND**
    f. For pediatrics, is being prescribed the Erythropoiesis Stimulating Protein by, or in consultation with, a specialist in hematology or nephrology

3. For renewals of prescriptions for a diagnosis of anemia associated with chronic renal failure, whether the recipient has:

    a. Documented increase in Hemoglobin; **AND**
    b. Hemoglobin
        i. ≤ 10 g/dL for recipients not on dialysis
        ii. ≤ 11 g/dL for recipients on dialysis; **AND**
    c. Transferrin or iron saturation ≥ 20% and ferritin ≥ 100ng/ml; **AND**
    d. Evaluation of vitamin B12 and folate levels with therapeutic supplementation as indicated; **AND**
    e. Adequately controlled blood pressure

AND

4. For a diagnosis of anemia in cancer patients on chemotherapy, whether the recipient:

    a. Is currently receiving myelosuppressive chemotherapy; **AND**
    b. Has Hemoglobin < 10 g/dL; **AND**
    c. Has transferrin or iron saturation ≥ 20% and ferritin ≥ 100ng/ml; **AND**
    d. Has an evaluation of vitamin B12 and folate levels with therapeutic supplementation as indicated; **AND**
    e. Has adequately controlled blood pressure

5. For renewals of prescriptions for a diagnosis of anemia in cancer patients on chemotherapy, whether the recipient has:

    a. A documented increase in Hemoglobin; **AND**
    b. Hemoglobin ≤ 12 g/dL; **AND**
    c. Transferrin or iron saturation ≥ 20% and ferritin ≥ 100ng/ml; **AND**
    d. An evaluation of vitamin B12 and folate levels with therapeutic supplementation as indicated; **AND**
    e. Adequately controlled blood pressure

AND

6. For a diagnosis of anemia in Zidovudine-treated HIV-infected patients, whether the recipient:

    a. Has a serum erythropoietin level ≤ 500 mUnits/mL; **AND**
    b. Is receiving a dose of zidovudine ≤ 4200 mg/week; **AND**
    c. Has Hemoglobin < 10 g/dL; **AND**
    d. Has transferrin or iron saturation ≥ 20% and ferritin ≥ 100ng/ml; **AND**
    e. Has an evaluation of vitamin B12 and folate levels with therapeutic supplementation as indicated; **AND**
    f. Has adequately controlled blood pressure

7. For renewals of prescriptions for a diagnosis of anemia in Zidovudine-treated HIV-infected patients, whether the recipient has:

    a. A documented increase in Hemoglobin; **AND**
    b. Hemoglobin ≤ 12 g/dL; **AND**
    c. Transferrin or iron saturation ≥ 20% and ferritin ≥ 100ng/ml; **AND**
    d. Evaluation of vitamin B12 and folate levels with therapeutic supplementation as indicated; **AND**
    e. Blood pressure is adequately controlled

AND

8. For a reduction of allogeneic blood transfusion in surgery patients, whether the recipient:

    a. Has Hemoglobin >10 to ≤ 13 gm/dL; **AND**
    b. Is undergoing elective, noncardiac, nonvascular surgery; **AND**
    c. Has transferrin or iron saturation ≥ 20% and ferritin ≥ 100ng/ml; **AND**
    d. Has an evaluation of vitamin B12 and folate levels with therapeutic supplementation as indicated; **AND**
    e. Has adequately controlled blood pressure

AND

9. For a diagnosis of anemia caused by Ribavirin in patients being treated for hepatitis C, whether the recipient has

    a. Hemoglobin < 10 g/dL or if symptomatic < 11 g/dL; **AND**
    b. An evaluation of vitamin B12 and folate levels with therapeutic supplementation as indicated; **AND**
    c. Transferrin or iron saturation ≥ 20% and ferritin ≥ 100 ng/mL; **AND**
    d. Adequately controlled blood pressure

10. For renewals of prescriptions for patients with a diagnosis of Ribavirin induced anemia, whether the recipient has:

    a. A documented increase in Hemoglobin; **AND**
    b. Hemoglobin ≤ 12 g/dL; **AND**
    c. An evaluation of vitamin B12 and folate levels with therapeutic supplementation as indicated; **AND**
    d. Transferrin or iron saturation ≥ 20% and ferritin ≥ 100ng/ml; **AND**
    e. Adequately controlled blood pressure

OR

11. The recipient does not meet the clinical review guidelines listed above, but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

C. Clinical Review Process

All requests for prior authorization of preferred and non-preferred Erythropoiesis Stimulating Proteins will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when the guidelines in Section B are met or when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

Gateway Health℠

It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

ERYTHROPOIESIS STIMULATING PROTEINS PRIOR AUTHORIZATION FORM

☐ **FOR ONCOLOGY USE**

☐ New request ☐ Renewal request — Total # of pgs: ________	Prescriber name:
Name of office contact:	Specialty: — Office NPI
Contact's phone number:	NPI: — State license #:
LTC facility contact/phone:	Street address:
Beneficiary name:	Suite #: — City/State/Zip:
Beneficiary ID#: — DOB:	Phone: — Fax:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)	Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other
Drug requested:	Strength & vial size: ☐ single-dose vial ☐ multi-dose vial
Dose/directions:	Quantity: — Duration:
Diagnosis *(submit documentation)*:	Dx code (*required*):
For non-preferred medication: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐ Yes ☐ No — *Submit documentation.*

Complete the section(s) below applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

- ☐ Has transferrin or iron saturation ≥ 20% and ferritin ≥ 100 ng/mL
- ☐ Has adequately controlled blood pressure
- ☐ Had vitamin B12 and folate levels evaluated and is receiving therapeutic supplementation as indicated
- ☐ **For treatment of anemia associated with chronic kidney disease – INITIAL request:**
  - ☐ Has irreversible kidney disease as defined by the National Kidney Foundation's KDOQI
  - ☐ Has hemoglobin < 10 g/dL
- ☐ **For treatment of anemia associated with chronic kidney disease – RENEWAL request:**
  - ☐ Has an increased hemoglobin level since starting treatment with the requested medication
  - ☐ Is receiving dialysis and has a hemoglobin ≤ 11 g/dL
  - ☐ Is not receiving dialysis and has a hemoglobin ≤ 10 g/dL
- ☐ **For treatment of anemia in patients with cancer receiving chemotherapy – INITIAL request:**
  - ☐ Is currently receiving myelosuppressive chemotherapy
  - ☐ Has hemoglobin < 10 g/dL
- ☐ **For treatment of anemia in patients with cancer receiving chemotherapy – RENEWAL request:**
  - ☐ Has an increased hemoglobin level since starting treatment with the requested medication
  - ☐ Has a hemoglobin ≤ 12 g/dL
- ☐ **For treatment of anemia in patients with HIV infection receiving zidovudine – INITIAL request:**
  - ☐ Has a serum erythropoietin level ≤ 500 mU/mL
  - ☐ Is taking zidovudine at a dose of ≤ 4200 mg/week
  - ☐ Has hemoglobin < 10 g/dL
- ☐ **For treatment of anemia in patients with HIV infection receiving zidovudine – RENEWAL request:**
  - ☐ Has an increased hemoglobin level since starting treatment with the requested medication
  - ☐ Has a hemoglobin ≤ 12 g/dL
- ☐ **For reduction of allogeneic blood transfusion in surgery patients:**
  - ☐ Has hemoglobin > 10 g/dL and ≤ 13 g/dL
  - ☐ Will be undergoing elective, non-cardiac, non-vascular surgery
- ☐ **For treatment of anemia caused by ribavirin in patients treated for hepatitis C virus infection – INITIAL request:**
  - ☐ Has hemoglobin < 10 g/dL or is symptomatic and has hemoglobin < 11 g/dL
- ☐ **For treatment of anemia caused by ribavirin in patients treated for hepatitis C virus infection – RENEWAL request:**
  - ☐ Has an increased hemoglobin level since starting treatment with the requested medication
  - ☐ Has a hemoglobin ≤ 12 g/dL

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

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Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

Prescriber Signature:	**Date**: