Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

Erythropoiesis-Stimulating Agents Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Drug name requested _____

Dose, frequency, and duration _____

Drug NDC (if known) or service code _____

Section I. Please complete for all requests.

Indication (Check all that apply.)

☐ **Anemia due to chronic renal failure**

Is the member receiving hemodialysis? ☐ Yes ☐ No (Please note, if the member is receiving hemodialysis, contact the dialysis clinic for proper billing procedure.)

Current hemoglobin _____ Date _____

Glomerular Filtration Rate (GFR) _____

Have other causes of anemia been ruled out (hemolysis, iron, vitamin B12, and folate deficiency)?

☐ Yes ☐ No. If no, please provide medical necessity for the use of requested agent. _____

_____

☐ **Anemia post-renal transplant**

Is the member receiving hemodialysis? ☐ Yes ☐ No (Please note, if the member is receiving hemodialysis, contact the dialysis clinic for proper billing procedure.)

Current hemoglobin _____ Date _____

☐ **Anemia due to cancer chemotherapy**

Current hemoglobin _____ Date _____

☐ **Anemia due to myelosuppressive medication regimen for Hepatitis C**

Please provide antiviral medication regimen and dates of therapy.

Antiviral medication(s) _____ Date _____

Current hemoglobin _____ Date _____

For members using ribavirin, has ribavirin dose reduction been attempted without success?
☐ Yes. Please provide current ribavirin dose (after reduction). _____
☐ No. Please provide medical necessity for the use of requested agent. _____
_____
Does the member have a history of cardiac disease? ☐ Yes ☐ No

☐ **Anemia due to myelosuppressive medication regimen for HIV**
Is member currently on zidovudine or zidovudine-containing products? ☐ Yes ☐ No
If yes, please provide current medication regimen. _____
Have other causes of anemia been ruled out (hemolysis, iron, vitamin B12, and folate deficiency)?
☐ Yes ☐ No. If no, please provide medical necessity for the use of requested agent. _____
_____
Current hemoglobin _____ Date _____

☐ **Decrease need for blood transfusions due to surgery**
Type of procedure _____Date of procedure _____
Please provide medical necessity for the use of requested agent. _____
_____
Current hemoglobin _____ Date _____

☐ **Other**
Please provide medical necessity for the use of erythropoietin (including diagnosis with etiology, current hemoglobin, other disease states, etc.). _____
_____

Please indicate billing preference. ☐ Pharmacy ☐ Prescriber in-office ☐ Hospital outpatient
For hospital outpatient billing, provide department-specific facility NPI. _____
Drug NDC (if known) or service code _____

Section II. Please also complete for recertification requests.

1. Is the member's hemoglobin currently > 12 g/dL?
   ☐ Yes. Please answer both questions below.
   Please provide the treatment plan to hold or reduce the erythropoietin dose.
   _____
   _____
   Date last erythropoietin dose was administered _____
   ☐ No
2. For members with anemia due to chemotherapy or myelosuppressive medication, please provide the most recent date of use for the causative agent.
   Medication(s) _____ Date _____

Section III. Please complete for Procrit and Retacrit requests.

Please provide clinical rationale for use of the requested agent instead of Epogen.
_____
_____

Section IV. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.
_____
_____
_____

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Prescriber information

Last Name* _____ First Name* _____ MI _____
NPI* _____ Individual MH Provider ID _____
DEA No. _____ Office Contact Name _____
Address _____ City _____ State _____ Zip _____
E-mail address _____
Telephone No.* _____ Fax No.* _____
* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required_____

Printed name of prescribing provider _____ Date _____