PRIOR AUTHORIZATION REQUEST

VAFSEO

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for initial therapy or for a continuation of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [Note: Example of response is an increase or stabilization in hemoglobin levels or a reduction or absence in red blood cell transfusion.] [No further questions.]	Yes	No
7	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
8	What is the indication or diagnosis? [] Anemia in a patient with chronic kidney disease (CKD) on dialysis (If checked, go to 9) [] All other indications or diagnoses (If checked, no further questions)		
9	Has the patient been receiving dialysis for at least 3 consecutive months? [If no, no further questions.]	Yes	No
10	Does the patient have a history of trial and failure to TWO of the preferred formulary medications for at least 3 months (such as Epogen and Procrit), or a contraindication, or intolerance, to all the formulary agents? ACTION REQUIRED: Submit supporting documentation. [Note: Failure is inability to obtain a Hemoglobin of 10 gram per deciliter (g/dL) despite maximal therapy.] [If no, no further questions.]	Yes	No
11	Has documentation been submitted to confirm baseline liver testing showing normal alanine transaminase (ALT), aspartate transaminase (AST), and bilirubin levels within the last 3 months? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient does NOT have	Yes	No

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	uncontrolled hypertension within the last 3 months? ACTION REQUIRED: Submit supporting documentation. [Note: Uncontrolled hypertension is defined as readings greater than or equal to 140/90 mmHG despite being on antihypertensive therapy.] [If no, no further questions.]		
13	Does the patient have a history of gastrointestinal erosion, or peptic ulcer disease? [If yes, no further questions.]	Yes	No
14	Is the patient currently receiving iron therapy or has documentation been submitted to confirm that the patient has adequate iron stores within the last 3 months (serum ferritin greater than or equal to 100 nanograms per deciliter [ng/mL] and transferrin saturation [TSAT] greater than or equal to 20%)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Does the patient have a history of myocardial infarction, cerebrovascular event, or acute coronary syndrome within the last 3 months? ACTION REQUIRED: Submit supporting documentation within the last 3 months. [If yes, no further questions.]	Yes	No
16	Does the patient have an active cancer diagnosis? ACTION REQUIRED: Submit supporting documentation within the last 3 months. [If yes, no further questions.]	Yes	No
17	Will the patient have concomitant use of any hypoxia-inducible factor prolyl-hydroxylases or probenecid? [If yes, no further questions.]	Yes	No
18	Is the requested medication being prescribed by or in consultation with a nephrologist or hematologist? [If no, no further questions.]	Yes	No
19	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: Initial 300 mg daily, not to exceed MAX 600 mg daily.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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