



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

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.). _____

Section II. Please also complete for requests for recertification.

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 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.

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

over

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 _____