DISTRICT OF COLUMBIA ~ DEPARTMENT OF HEALTH ~ ADAP

Epoetin Alfa for injection (Procrit®, Epogen®)

PRIOR AUTHORIZATION PROGRAM Request Form- Initial Request 6 months maximum

CLIENT'S NAME: _____ ADAP ID: _____

CLIENT'S DATE OF BIRTH: _____ ADAP Pharmacy: _____

DC ADAP Policy: Epogen®, Procrit® (epoetin alfa) is a glycoprotein that stimulates erythropoiesis by the same mechanism as endogenous erythropoietin to increase red blood cell production. It is available as single-dose vials containing 2000, 3000, 4000, 10,000 and 40,000 units/1mL. Multidose vials containing benzyl alcohol are also available at 20,000 units/2mL and 20,000 units/1mL.

Epogen® and Procrit® require prior approval for coverage. Allow up to 96 hours for completion of request.

Please Fax Laboratory report and medical record documentation of anemia diagnosis.

Indication for Use:
Erythropoietin has been approved for use in clients to treat anemia due to zidovudine; cancer chemotherapy; or chronic renal failure (predialysis).

Criteria for use:
Please complete and check all that apply:

1. Medical Provider is experienced in the use of erythropoietin for anemia.

   YES ☐ NO ☐

2. Client's indication for erythropoietin use is

   □ Zidovudine-related anemia
   □ Anemia secondary to cancer chemotherapy; prescriber certified with APPRISE
   □ Anemia of chronic renal failure (predialysis)
   □ Other _____

3. Client does not have uncontrolled hypertension.

   YES ☐ NO ☐

4. Client does not have a history of seizures.

   YES ☐ NO ☐

5. Client has received previous epoetin alfa therapy.

   YES ☐ NO ☐ If yes, indicate results_____

6. Client has been informed of potential benefits and risks associated with epoetin alfa. If the use is for cancer-related anemia, please fax the completed APPRISE acknowledgement form.

   YES ☐ NO ☐

7. Client's anticipated start date of epoetin alfa is_____.

8. Client's anticipated duration of treatment is _____ months.

9. Provide the following most recent client information:

   Dose _____ Weight (kg)_____ Height (in) _____

   Hgb _____ Hct _____ Date _____

Recommended dosage and administration:

- **Initial** recommended dose of epoetin alfa is 100 Units/kg 3 times weekly.
- If response is unsatisfactory after 8 weeks, **increase dose** by 50 to 100 units/kg at 4-to 8-week intervals, until hemoglobin reaches a level needed to avoid RBC transfusions, not exceeding dose of 300 units/kg three times per week.
- Withhold epoetin alfa if hemoglobin exceeds 12g/dL and continue at 25% below previous dose when hemoglobin is below 11g/dL.
- Discontinue if increase in hemoglobin is not achieved with a dose of 300 units/kg for 8 weeks.
- Screen patients for other anemic processes including B12, folate and iron deficiencies. Supplement as required.

Physician's signature: _____ Date: _____

Physician's Name (Print): _____Phone #: _____Fax #: _____

Fax Completed Form to Clinical Pharmacy Associates, Inc.

Fax: 1 (888) 971-7229 Phone: 1 (800) 745-0434 ext 150 Attention: Prior Approval Program

Approval: YES □ NO □ Date_____ Initials_____ Office use only

Reason for denial_____