

Physician Request Form for PROCRIT®

Fax non-urgent requests to PerformRx Pharmacy Services at 877-693-8280 or urgent requests to 877-693-8476. Urgent requests should be reserved for situations in which the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call 800-578-0898. Form must be completed for processing



Patient Name: Address: City: State: Phone #:

Plan ID#: Apt # or Suite #: Zip Code: Birthdate:

Physician Name: Address: City: State: Contact Person: Phone #:

NPI #: Apt # or Suite #: Zip Code: Fax #:

Physician Signature: LTC member Yes No, Date Admitted

Deliver to Patient's Home Deliver to Physician's Office Pick-up at Local Pharmacy (Name/Phone#):

PROCRIT

Naive Therapy Continuation of Therapy Patient weight: lbs or kg

To be Administered From: to OR on:

Is the patient on concurrent iron therapy? (please check) Yes No If yes, indicate iron regimen:

Is the patient on folate and/or vitamin B12 therapy? (please check) Yes No If yes, indicate regimen: (Virtually all patients will eventually require supplemental iron therapy to increase/maintain transferrin saturation to levels which will adequately support erythropoiesis stimulated by Procrit - TSAT>20% and Ferritin >100 ng/mL required to avoid functional iron deficiency)

Labs (Please submit a copy of the most recent labs and/or complete the following - lab values should be within 30 days of request)

Hb: g/dL Hct: % Date of labs:

GFR ml/min/1.73m2 Has the patient met the criteria for CKD (as defined by KDOQI) for >= 3 months? (please check) Yes No

TSAT: % (TSAT>20% and Ferritin >100 required to avoid functional iron deficiency) Ferritin: ng/mL Date of labs:

Vitamin B12 level: Date: Folic Acid Level: Date:

(If baseline B12 and Folic acid levels are within normal limits, repeat levels not necessary for reauthorization)

Diagnosis (please check the appropriate diagnosis box and fill out the requested information)

ANEMIA DUE TO HIV REALATED CAUSES - Recommended starting dose=100 U/kg three times a week

Is the Patient receiving AZT (Retrovir® Zidovudine) therapy? {Circle one} YES NO

ANEMIA DUE TO CHEMOTHERAPY - Recommended starting dose=150 U/kg three times a week

NOTE: All patients must be advised of the benefits/risks of ESA treatment and must receive the Procrit Medication Guide. ESAs are not indication for patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure.

Is the Patient currently receiving chemotherapy? {Circle one} YES NO

Please Specify Chemotherapy Regimen and Date(s) of treatment:

Administering Procrit in smaller doses two or three times a week (i.e. 10,000 Units three times a week) is as effective as administering a higher, once weekly dose (i.e. 40,000 Units weekly) and has the advantage of administering less drug.

Rx for Chemotherapy OR HIV Anemia: Procrit Units Sig:

Requested Duration:

ANEMIA DUE TO CHRONIC RENAL FAILURE

Recommended starting dose=80-120 U/kg weekly (typically 6,000 U/week)

Rx Procrit Units Sig:

Requested Duration:

ANEMIA DUE TO OTHER CAUSES

Diagnosis:

Rx Procrit Units

Sig:

Requested Duration:

Medical Reason for Prescribing Procrit instead of Aranesp:

