KEYSTONE MERCY HEALTH PLAN
A Program of Keystone First and Mercy Health Plan

Physician Request Form for PROCRIT®

Fax to Pharmacy Services at 215-937-5018, or to speak to a Representative call **800-588-6767**. *Form must be completed for processing.*

Patient Name: ______________________ Member ID#: ______________
Address: ______________________ Apt # or Suite #: ______________
City: ______________ State: ________ Zip Code: ______________
Phone #: ______________________ Birth Date: ______________

Physician Name: ______________________ NPI #: ______________
Address: ______________________ Apt # or Suite #: ______________
City: ______________ State: ________ Zip Code: ______________
Contact Person: ______________ **Phone #:** ______________ **Fax #:** ______________
Physician Signature:______________________________

❑ 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: __________

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:________________

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

(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=40,000 units weekly

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

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

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Does patient have any anemia risk factors (i.e., Co morbidities – CHF, CAD, highly myelosuppressive chemo treatment, radiation therapy, etc)? {Circle one} YES NO
If yes, please specify______________________________

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:______________________________

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