Alabama Drug Assistance Program (ADAP)

Supplemental/Authorization Form for Procrit® (epoetin alfa)

TELEPHONE: 888-311-7632 FAX: 800-848-4241

Please complete the ALL sections below for determination of treatment authorization

PROCRIT® (epoetin alfa) is an erythropoiesis-stimulating agent (ESA) indicated for:

- Treatment of anemia due to:
  - Chronic Kidney Disease (CKD) in patients on dialysis and not on dialysis.
  - Zidovudine in patients with HIV-infection
  - The effects of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy
- Reduction of allogeneic RBC transfusions in patients undergoing elective, noncardiac, nonvascular surgery

Source- http://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/PROCRIT-pi.pdf

PROCRIT® (epoetin alfa) is available to AL ADAP enrollees who meet the medical criteria outlined below

Prescriber Name and Signature must be included. Please fax completed application to Ramsell at 800-848-4241.For additional information, call the Ramsell Help Desk at: 1-888-311-7632. Clinicians will be notified of the approval decision by Ramsell

All supporting labs and chart documentation are REQUIRED for approval of this request.

Section 1 Patient First & Last Name: DOB: RW ID #:

Section 2 Medical Indications and Treatment

What is the planned treatment regimen and duration? (Please fill in):

☐ Drug Name including strength and daily dosing :

_____

YES	NO	(Check ALL the medical criteria stated below that apply)
☐	☐	1. History of symptoms referable to anemia
☐	☐	2. History of transfusion to treat anemia
☐	☐	3. Hbg <10g/dl. List most recent value and date of lab work _____
☐	☐	4. Endogenous serum erythropoietin (EPO) level ≤ 500mUnits/mL List most recent level and date of lab work_____
☐	☐	5. Dose of Zidovudine ≤4200 mg/week. Current dose _____mg/week
☐	☐	6. Work-up of other causes of anemia (e.g. iron or folate deficiency, hemolysis etc.)

List other symptoms or indications:_____

Date: **To the best of my knowledge, I certify that the above is accurate and true.**

Prescriber Name Prescriber Signature

Phone # Fax #

Pharmacy Name Pharmacy Phone # Fax #

REQUIRED DOCUMENTATION - Please submit ALL required clinical notes/ lab reports in reference to this request. Failure to provide documentation will delay decision process.

☐ Blood lab work (including Hbg & EPO levels) ☐ Proof of History of anemia symptoms

☐ Proof of History of blood transfusion if applicable ☐ Work-up of other causes of anemia if applicable