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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Retacrit® Prior Authorization Request Form (Page 1 of 3)

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Member Information <small>(required)</small>	Provider Information <small>(required)</small>
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Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>
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Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information <small>(required)</small>
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Select the diagnosis below:

Anemia due to hepatitis C virus (HCV) treatment

Anemia in cancer patients on chemotherapy

Anemia in chronic kidney disease (CKD)

Anemia in HIV-infected patients

Anemia in myelodysplastic syndrome (MDS)

Preoperative use for reduction of allogeneic blood transfusion in patients undergoing surgery

Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is the patient on dialysis? Yes No

Does the patient have end-stage renal disease (ESRD)? Yes No

Is the dialysis provider (i.e., nephrologist, nurse practitioner, physician assistant, or dialysis center) receiving a monthly capitation payment to manage the patient's ESRD care? Yes No

Has the patient been evaluated for adequate iron stores? Yes No

Is this request for continuation of prior therapy with Retacrit? Yes No

Select if the patient has history of failure, contraindication, or intolerance to the following, if appropriate for the patient's diagnosis:

Aranesp Procrit

For anemia due to hepatitis C virus (HCV) treatment, also answer the following:

Does the patient have a diagnosis of hepatitis C virus (HCV) infection? Yes No

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within **30 days** of this request:

Hgb: _____ g/dL Hct: _____ % Date: _____

Select if the patient is receiving the following:

Ribavirin Interferon alfa Peg-interferon alfa

Reauthorization:

Document the monthly hemoglobin (Hgb) and hematocrit (Hct) levels collected over a **3 month** period:

Hgb: _____ g/dL Hct: _____ % Date: _____

Hgb: _____ g/dL Hct: _____ % Date: _____

Hgb: _____ g/dL Hct: _____ % Date: _____

Has the patient had a decrease in the need for blood transfusion? Yes No

Has the patient's hemoglobin (Hgb) increased by 1 g/dL or more from pre-treatment level? Yes No

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Retacrit_CMS_2019Jan-W



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For anemia in cancer patients on chemotherapy, also answer the following:

Have all other causes of anemia been ruled out? Yes No

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within **2 weeks** of this request:

Hgb: _____ g/dL Hct: _____ % Date: _____

Is the patient's cancer a non-myeloid malignancy? Yes No

Is the patient concurrently on chemotherapy? Yes No

Will the patient be receiving concomitant chemotherapy for a minimum of 2 months? Yes No

Is the anemia caused by the cancer chemotherapy? Yes No

Reauthorization:

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within **2 weeks** of this request:

Hgb: _____ g/dL Hct: _____ % Date: _____

Has the patient had a decrease in the need for blood transfusion? Yes No

Has the patient's hemoglobin (Hgb) increased by 1 g/dL or more from pre-treatment level? Yes No

Is the patient currently on chemotherapy? Yes No

Will the patient be receiving concomitant chemotherapy for a minimum of 2 months? Yes No

Is the anemia caused by the cancer chemotherapy? Yes No

For anemia in chronic kidney disease (CKD) , also answer the following:

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within **30 days** of this request:

Hgb: _____ g/dL Hct: _____ % Date: _____

Does the rate of hemoglobin decline indicate the likelihood of requiring a red blood cell (RBC) transfusion? Yes No

Is reducing the risk of alloimmunization and/or other RBC transfusion-related risks a goal? Yes No

Reauthorization:

Document the monthly hemoglobin (Hgb) and hematocrit (Hct) levels collected over a **3 month** period:

Hgb: _____ g/dL Hct: _____ % Date: _____

Hgb: _____ g/dL Hct: _____ % Date: _____

Hgb: _____ g/dL Hct: _____ % Date: _____

Has the patient had a decrease in the need for blood transfusion? Yes No

Has the patient's hemoglobin (Hgb) increased by 1 g/dL or more from pre-treatment level? Yes No

Has the patient been evaluated for adequate iron stores? Yes No

For anemia in HIV-infected patients, also answer the following:

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within **30 days** of this request:

Hgb: _____ g/dL Hct: _____ % Date: _____

Is the serum erythropoietin level 500 mU/mL or less? Yes No

Does the patient have a diagnosis of HIV infection? Yes No

Is the patient receiving zidovudine (AZT) therapy? Yes No

Reauthorization:

Document the monthly hemoglobin (Hgb) and hematocrit (Hct) levels collected over a **3 month** period:

Hgb: _____ g/dL Hct: _____ % Date: _____

Hgb: _____ g/dL Hct: _____ % Date: _____

Hgb: _____ g/dL Hct: _____ % Date: _____

Has the patient had a decrease in the need for blood transfusion? Yes No

Has the patient's hemoglobin (Hgb) increased by 1 g/dL or more from pre-treatment level? Yes No



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For anemia in myelodysplastic syndrome (MDS) , also answer the following:

Does the patient have a serum erythropoietin level of 500 mU/mL or less? Yes No

Does the patient have transfusion-dependent MDS? Yes No

Reauthorization:

Document the monthly hemoglobin (Hgb) and hematocrit (Hct) levels collected over a **3 month** period:

Hgb: _____ g/dL Hct: _____ % Date: _____

Hgb: _____ g/dL Hct: _____ % Date: _____

Hgb: _____ g/dL Hct: _____ % Date: _____

Has the patient had a decrease in the need for blood transfusion? Yes No

Has the patient's hemoglobin (Hgb) increased by 1 g/dL or more from pre-treatment level? Yes No

For preoperative use for reduction of allogeneic blood transfusion in patients undergoing surgery, also answer the following:

Is the patient scheduled to undergo elective, non-cardiac, or non-vascular surgery? Yes No

Is the hemoglobin (Hgb) greater than 10 g/dL to less than or equal to 13 g/dL? Yes No

Is the patient at high risk for perioperative transfusions? Yes No

Is the patient unwilling or unable to donate autologous blood pre-operatively? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.