Physician Request Form for PROCRIT®

Fax to Pharmacy Services at **855-811-9332**, or to speak to a Representative, call **888-602-3741**. *Form must be completed for processing.*

AmeriHealth Caritas District of Columbia

Patient Name: _____ Patient 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: _____

_____ _____

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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