

Confidential

2181 E Aurora Rd Ste 201
Twinsburg OH 44087

Phone: 330-405-8080
Fax: 330-405-8081

Envision/Rx Options, Inc.

To:	From: Envision Rx Options Clinical Staff
Fax:	Pages: 3 inc cover
Phone:	Date:
Re: <i>Prior Authorization for Elderplan Member</i>	

Dear Provider,

Envision Rx Options / Elderplan requires a Prior Authorization for Aranesp, Epogen, and Procrit for its members.

Attached is a Prior Authorization Form for one of these medications for Elderplan Member : _____

Comments:

*Please complete the form and fax back to **330-405-8081** attn: **Clinical Dept***

*Thank you,
The Clinical Staff
Envision Pharmaceutical Services*

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FOR ENVISION INTERNAL USE ONLY – Date and Time Received Completed form from Doctor

ENVISION Rx OPTIONS/ ELDERPLAN

Prior Authorization Request for Aranesp, Epogen, and Procrit

Fax Completed Form to: 330-405-8081 or Call 330-405-8080 for phone requests

A separate request must be completed for each drug for each patient.

Please note: **Approvals will be for three (3) months only. Prior authorization will be required, with updated clinical information (lab values), after a three (3) month period.**

Patient Information			Physician Information		
Patient Name			Name:		
Member ID#	Group#	Carrier	Office Phone:		
Gender: M <input type="checkbox"/> F <input type="checkbox"/>		Date of Birth:	Secure Office Fax Number:		
Office Contact Name:			NPI #		
Drug Name :					
Dose:		Directions:		Quantity:	
Initial Therapy?	Y	N	Continuing Therapy?	Y	N
			Has Dose Been Titrated?	Y	N

Indications	Lab Values
All Patients	
Please Check Below:	Hb _____ Date _____
_____ anemia associated with end stage renal disease (ESRD) GFR<15, dialysis	(Hemoglobin 11 g/dl or less recommended for all indications EXCEPT anemia due to chemotherapy)
_____ anemia associated with chronic renal failure (CRF) with GFR< 60	(Hemoglobin less than 10 g/dl recommended for anemia due to chemotherapy)
_____ anemia associated with the use of chemotherapy in the treatment of cancer (Hb <10 recommended)	Hct _____ Date _____
_____ anemia associated with zidovudine (AZT) treatment in HIV infected patients	CKD Patients Only
_____ anemia in patients scheduled to undergo elective, non- cardiac, nonvascular surgery to reduce the need for allogeneic blood transfusions	BUN _____ Date _____
_____ Myelodysplastic Syndrome	Serum Creatinine _____ Date _____
	GFR _____ Date _____

****Supporting Clinical Statement** (such as applicable protocols or guidelines followed, contraindications, drug allergies, dialysis, or any other additional clinical information to support medication request):

Expedited Review (24 hours): The 72 hour standard review may seriously jeopardize the health or life of the member or the member's ability to regain maximum function (please explain above).

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA. Prior Authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient.

FOR ENVISION INTERNAL USE ONLY –

Sender Information:

Reviewed by: _____

If Approved, Date and Time of Determination: _____

If Denied, Date and Time of Determination _____

If Approved,

Date and Time of Communication to Pharmacy _____