Confidential

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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: ***Prior Authorization for Elderplan Member***

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

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 ☐ F ☐	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
Please Check Below:	**All Patients**
______ anemia associated with end stage renal disease (ESRD) GFR<15, dialysis	Hb ____________ Date __________
_______ anemia associated with chronic renal failure (CRF with GFR< 60	**(Hemoglobin 11 g/dl or less recommended for all indications EXCEPT anemia due to chemotherapy)**
______ anemia associated with the use of chemotherapy in the treatment of cancer **(Hb <10 recommended)**	**(Hemoglobin less than 10 g/dl recommended for anemia due to chemotherapy)**
______ anemia associated with zidovudine (AZT) treatment in HIV infected patients	Hct ___________ Date __________
______ anemia in patients scheduled to undergo elective, non- cardiac, nonvascular surgery to reduce the need for allogeneic blood transfusions	**CKD Patients Only**
	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 ______________________