Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Erythropoietin Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for all erythropoietin products. Information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home ☐ nursing facility		Height	Weight	

Medication information (When appropriate, please consider multidose vial use.)

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code

Indication for erythropoietin (Check one or all that apply.):

☐ Chronic renal failure
Is the member on hemodialysis? ☐ Yes ☐ No
(Please Note: If member is on hemodialysis, please contact dialysis clinic for proper billing procedure.)
Please provide most recent serum creatinine and/or creatinine clearance.

☐ Renal transplant
Is the member on hemodialysis? ☐ Yes ☐ No

☐ Cancer chemotherapy
Please provide type of cancer and dates chemotherapy will be given.

☐ Hepatitis C
Please provide antiviral medication regimen and any dose adjustments attempted.

☐ HIV
Please provide medication regimen.

☐ Anemic surgical patient
Type of procedure:
Date of procedure:
Please provide medical necessity for the use of erythropoietin:

☐ Other
Please provide medical necessity for the use of erythropoietin

over ▶

Laboratory information

Current Hematocrit/Hemoglobin: _____ date: _____

Erythropoietin level (if available): _____

Have other causes of anemia been ruled out (hemolysis, iron, vitamin B12, and folate deficiency)? Yes ☐ No ☐

If no, please provide further justificatiion for erythropoietin.

_____

Continuation of therapy

Please complete sections above about indication for erythropoietin and labratory information.

Please provide documentation of member's response to therapy (e.g., quality of life, activities of daily living).

_____

_____

_____

_____

Has member been transfused in past six months? ☐ Yes ☐ No

If yes, please provide explanation. _____

_____

_____

Target hematocrit: _____

_____

If target hematocrit has been met, please provide plan for decreasing dose. _____

_____

_____

Pharmacy information

Name	Pharmacy provider no. *Optional*	Telephone no. ( )	Fax no. ( ) *Optional*	
Address		City	State	Zip *Optional*

Prescriber information

Last name	First name	MI	MassHealth provider no. *Optional*	DEA no.	
Address			City	State	Zip
E-mail address *Optional*			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Prescriber's signature (Stamp not accepted.) Date