TEXAS MEDICAID
Clinical Edit Prior Authorization
epoetin alfa (PROCRIT)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

NAVITUS HEALTH SOLUTIONS

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of chronic renal failure in the last 730 days?

   ☐ Yes (Go to #7) ☐ No (Go to #2)

2. Does the client have a diagnosis of cancer in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Go to #5)

3. Does the client have a history of an antineoplastic agent in the last 30 days?

   Examples of antineoplastic agents include ALKERAN, anastrozole (ARIMIDEX), azacitidine, bicalutamide (CASODEX), BICNU, BOSULIF, capecitabine (XELODA), CAPRELSA, COMETRIQ, COSMEGEN, cyclophosphamide, CYTARABINE, DROXIA, EFUDEX, EMCYT, ERIVEDGE, etoposide, exemestane (AROMASIN), FARESTON, FARYDAK, flutamide, GLEEVEC, GLEOSTINE, HEXALEN, HYCAMTIN, hydroxyurea, IBRANCE, ICLUSIG, IMBRUVICA, INLYTA, IRESSA, JAKAFI, LENVIMA, letrozole (FEMARA), LEUKERAN, LYSODREN, MATULANE, megestrol acetate (MEGACE), MEKINIST, mercaptopurine (PURIXAN), methotrexate (RHEUMATREX, TREXALL), mitomycin, mitoxantrone, MYLERAN, NEXAVAR, NILANDRON, OFEV, ONCASPAR, SPRYCEL, STIVARGA, SUTENT, SYNRIBO, TABLOID, tamoxifen (SOLTAMOX), TARCEVA, TARGRETIN, TASIGNA, temozolomide (TEMODAR), TYKERB, vinblastine, VOTRIENT, XALKORI, XTANDI, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA, and ZYTIGA.

   ☐ Yes (Go to #7) ☐ No (Go to #4)

4. Does the client have a history of chemotherapy in the last 30 days?

   ☐ Yes (Go to #7) ☐ No (Go to #5)

5. Does the client have a history of Human Immunodeficiency Virus (HIV) in the last 730 days?

   ☐ Yes (Go to #6) ☐ No (Deny)

6. Does the client have a history of zidovudine in the last 90 days?

   ☐ Yes (Go to #7) ☐ No (Deny)

7. Does the client have a history of an erythropoiesis-stimulating agent (ESA) in the last 90 days?

   Examples include ARANESP, EPOGEN, PROCRIT, and RETACRIT.

   ☐ Yes (Go to #8) ☐ No (Approve - 365 days)

8. Does the client have a history of a complete blood count (CBC) in the last 90 days?

   ☐ Yes (Go to #9) ☐ No (Deny)

9. Does the client have a history of ferritin and iron binding capacity (IBC) tests in the last 180 days?

   ☐ Yes (Approve - 365 days) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.