carolina complete health

Pharmacy Prior Approval Request for Hematinics: Procrit/Epogen/Aranesp/Mircera/Retacrit

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

For Non-preferred Drugs:

☐ Failed two preferred drugs. If only one drug is available, then failed one preferred drug.
Please List: _____

☐ Allergic Reaction: Please provide reaction - _____

☐ Drug-to-Drug interaction: Please list interaction - _____

☐ Previous episode of an unacceptable side effect or therapeutic failure: _____

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred Drugs: _____

☐ Age specific indications: _____

☐ Unique clinical indication supported by FDA approval or peer reviewed literature: _____

☐ Unacceptable clinical risk associated with therapeutic change: _____

1. Is this new therapy? Select "Yes" for new therapy. Select "No" for continued therapy. ☐ **Yes** ☐ **No**
2. What is the diagnosis or the indication for the product?

☐ Anemia associated with renal failure

☐ Anemia associated with HIV infection

☐ Anemia associated with chemotherapy

☐ Anemia associated with myelodysplastic syndromes

☐ Drug induced anemia such as with ribavirin or zidovudine

3. Lab Test Date Within the Last 3 Months? Date: _____ Hemoglobin: _____
4. Dosage: _____ 3b. Frequency: _____

Signature of Prescriber:_____Date: _____

(Prescriber Signature Mandatory)

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.

Fax this form to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309
https://www.covermymeds.com/main/prior-authorization-forms/