

**Pharmacy Prior Approval Request for Hematinics:
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
 Sickle Cell Disease
 3. Lab Test Date Within the Last 3 Months? Date: _____ Hemoglobin: _____
 3b. Frequency: _____
 4. Dosage: _____

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

