sunshine health

MEDICATION PRIOR AUTHORIZATION REQUEST FORM
FAX this completed form to 1-833-546-1507
OR Mail request to: Pharmacy Services Prior Authorization Dept.
5 River Park Place East, Suite 210 | Fresno, CA 93720
Call 1-866-399-0928 to request a 72-hour supply of medication.
Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

Reset Form | Print Form

Erythropoiesis Stimulating Agents

Clinical PA (preferred): Retacrit™/Aranesp®
Non-preferred: Mircera®/Procrit® /Epogen®
(Maximum Length of Approval = 6 Months)

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber's Phone Number ___ - ___ - ____

Prescriber's Fax Number ___ - ___ - ____

MEDICATION	**STRENGTH:**	**DIRECTIONS:**
☐ Aranesp ☐ Mircerna ☐ Retacrit ☐ Epogen ☐ Procrit		

Weight: _____ **lbs or** _____ **kgs as of** _____ **(date)** ☐ **INITIATION OF THERAPY** -OR- ☐ **CONTINUATION OF THERAPY**

MEDICAL HISTORY

Anemia due to renal failure?	☐ Yes ☐ No	**If yes, please complete the following:**	☐ Acute ☐ Chronic
Dialysis?	☐ Yes ☐ No	**Place dialysis received:**	☐ Home ☐ Dialysis Center
Anemia due to chemotherapy	☐ Yes ☐ No	**Is anemia due to hemolysis?**	☐ Yes ☐ No
Anemia due to antiretroviral therapy?	☐ Yes ☐ No	**Is anemia due to folate or iron deficiency?**	☐ Yes ☐ No
Is patient currently receiving iron supplements?	☐ Yes ☐ No	**Is anemia due to a GI bleed?**	☐ Yes ☐ No

Is patient scheduled to undergo elective, noncardiac, or nonvascular surgery and at high risk for perioperative transfusions? ☐ Yes ☐ No
Willing to donate blood? ☐ Yes ☐ No

NOTE: Official lab reports must be submitted and dated within 2 months of the PA. Form and lab data must be completed in full.

Hemoglobin Level (g/dL): _____	**Hematocrit (%):** _____
Date of lab: _____	**Date of lab:** _____
Serum Ferritin ≥ 100 ng/mL: ☐ Yes ☐ No	**Serum Tranferrin Saturation ≥ 20% :** ☐ Yes ☐ No
Date of lab: _____	**Date of lab:** _____

Serum Erythropoietin Level: ☐ **≤ 200** ☐ **> 200 to 500** **Date of lab:** _____

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes) and the most recent copies of related labs. **The provider must retain copies of all documentation for five years.**