

## 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.

## **Erythropoiesis Stimulating Agents**

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

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

The state of the s				
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		
Prescriber's Priorie Number		Prescriber 51 ax Num		
MEDICATION STRENGTH: DIRECTIONS:				
Aranesp Mircerna Re	tacrit			
Epogen Procrit		<u>_</u>		
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?				
Willing to donate blood?				
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:	es 🗌 No	Serum Tranferrin Saturation ≥ 20% :	Yes No	
Date of lab: Date of lab:				
Serum Erythropoietin Level: ☐ ≤	200	to 500 Date of lab:		
Prescriber's Signature: Date:				
REQUIRED FOR REVIEW: Copies of medical		valuations and recent chart notes) and the most rec		
provider must retain copies of all documentation for five years.				

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