



Request for Prior Authorization
ERYTHROPOIESIS STIMULATING AGENTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization (PA) is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia. Payment for non-preferred erythropoiesis stimulating agents will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s).

Preferred

Procrit

Non-Preferred

Aranesp, Epogen

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

Hemoglobin: % Lab Test Date: (Lab Test must be within 4 weeks of the PA request date)

Transferrin Saturation: Ferritin: Lab Test Date: (Lab Test must be within 3 months of the PA request date)

Is the patient currently on dialysis? Yes No

Is the patient on concurrent therapeutic iron therapy? Yes No

If yes, what is the current drug name, strength & dose?

Does the patient have active gastrointestinal bleeding? Yes No If yes, what is the current treatment?

Does the patient have hemolysis? Yes No

Does the patient have a vitamin B-12, iron, or folate deficiency? Yes No

Previous Erythropoiesis Stimulating Agent therapy (include drug name(s), strength and exact date ranges) :

Reason for use of Non-Preferred drug requiring prior approval:

Attach lab results and other documentation as necessary.

Form with fields for Prescriber signature (Must match prescriber listed above.) and Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.