**FAX Completed Form To**
1.833.404.2392
**Pharmacy Help Desk**
1.800.460.8988
**Prescriber Help Desk**
1.833.587.2012

# Request for Prior Authorization
# ERYTHROPOIESIS STIMULATING AGENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

| IA Medicaid Member ID # | Patient name | DOB |
|---|---|---|
| Patient address | | |
| Provider NPI | Prescriber name | Phone |
| Prescriber address | | Fax |
| Pharmacy name | Address | Phone |
| **Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.** | | |
| 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**
☐ Mircera ☐ Retacrit

**Non-Preferred**
☐ Aranesp ☐ Procrit
☐ 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.***

| Prescriber signature (Must match prescriber listed above.) | 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. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*