FAX Completed Form To
1.877.386.4695
Provider Help Desk
1.866.399.0928

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
☐ Epogen ☐ Retacrit

Non-Preferred
☐ Aranesp ☐ Procrit
☐ Mircera

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.*

Rev. 1/20