FLORIDA MEDICAID PRIOR AUTHORIZATION				
Erythropoiesis Stimulating Agents				
Clinica	I PA (preferred): Aranesp [®] /Epogen [®] /Retacri	t™	
FLORIDA [®] COMMUNITY CARE	Non-preferr	ed: Mircerna®/Procrit® 🛛 🖌 🖌	CVS caremark [®]	
	•	ngun of Approval – 6 Monuns)		
Note: F	orm must be complete	d in full. An incomplete form may be returned	1.	
Recipient's Medicaid ID#	Date o	of Birth (MM/DD/YYYY)		
Recipient's Full Name				
Prescriber's Full Name				
Prescriber's NPI				
Prescriber's Phone Number	riber's Phone Number Prescriber's Fax Number			
MEDICATION STRENGTH: DIRECTIONS: Aranesp Mircerna Retacrit Epogen Procrit				
Weight: Ibs or kgs as of (date) INITIATION OF THERAPY -OR- I CONTINUATION OF THERAPY				
	ME	EDICAL 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?				
NOTE: Official lab reports must be sub	mitted and dated wit	hin 2 months of the PA. Form and lab data	a must be completed in full.	
Hemoglobin Level (g/dL): Hemoglobin Level (g/dL):		Hematocrit (%):		
Date of lab:		Date of lab:		
Date of lab:		Serum Ferritin ≥ 100 ng/mL: Yes No Serum Tranferrin Saturation ≥ 20% : Yes No		
	es 🗌 No	Serum Tranferrin Saturation ≥ 20% :	🗌 Yes 🗌 No	
		Serum Tranferrin Saturation ≥ 20% : Date of lab:		
Serum Ferritin ≥ 100 ng/mL:		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.

Call or Fax Information to: Florida Community Care Prior Authorization

Phone number for non-specialty Prior Authorization: 877-433-7643 Phone number for specialty Prior Authorization: 866-814-5506 Fax number for non-specialty Prior Authorization: 866-255-7569 Fax number for non-specialty Prior Authorization: 866-249-6155 **Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.