FLORIDA MEDICAID PRIOR AUTHORIZATION

Erythropoiesis Stimulating Agents

Clinical PA (preferred): Aranesp®/Epogen®/Retacrit™



Non-preferred: Mircerna®/Procrit®

(Maximum Length of Approval = 6 Months)

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



| Recipient's Medicaid ID# Date o | | | | | | | | | | | | of Birth (MM/DD/YYYY) | | | | | | | | | | | | | | | | | |
|--|--|-------|------|------|-------|---------|-----|----------|--------|--------|--------|-----------------------|------|--|------|-------|------|------|-------|--------|-----|-----|-------------------------------------|---|---|-------|------|---|--|
| | | | | | | | | | | | | | | / | | | / | | | | | | | | | | | | |
| Recipient's Full Name | | | | | | | | | | | | | | |] | | | 1 | 1 |] | | | | | T | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prescriber's Full Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prescriber's NPI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prescriber's Phone Number | | | | | | | | | | | | | | | | | | Pres | scrib | er's | Fax | Num | ber | 1 | | | 1 | | |
| | | | _ | | | | - | | | | | | | | | | | | | | - | | | | - | | | | |
| MED | ICAT | ION | | | | | | | | ST | REN | GTH: | | | | DIREC | TION | IS: | | | J | | | | | | | | |
| | Aranesp Mircerna Retacrit Epogen Procrit | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Weight: Ibs or kgs as of (date) INITIATION OF THERAPY -OR- CONTINUATION OF THERAPY | | | | | | | | | | | | | | | (PY | | | | | | | | | | | | | | |
| Ano | | | | | | | | | | | | | | IDICAL HISTORY | | | | | | | | | | | | | | | |
| Anemia due to renal failure? | | | | | | | | | | | | | | If yes, please complete the following: Place dialysis received: | | | | | | | | | Acute Chronic Home Dialysis Center | | | | | _ | |
| | Dialysis? | | | | | | | | | | | | | - | | | | | | | | | | | | s Cei | nter | | |
| | Anemia due to chemotherapy Yes No | | | | | | | | | | | | | Is anemia due to hemolysis? Is anemia due to folate or iron deficiency? | | | | | | | | | Yes No | | | | | | |
| | Anemia due to antiretroviral therapy? Yes No | | | | | | | | | | | | | | | | | | | | | | Yes No | | | | | | |
| | Is patient currently receiving iron | | | | | | | | | | | | Is | 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? | | | | | | | | | | | | | | |] No | | | | | | | | | | | | | | |
| | 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hen | Hemoglobin Level (g/dL): | | | | | | | | | | | | | Hematocrit (%): | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | Date of lab: | | | | | | | | | | | | | | | |
| | - – | | | | | | | | | | | | | Serum Tranferrin Saturation ≥ 20% : | | | | | | | | | | | | | | | |
| Date | of I | ab: _ | | | | | | | | | | _ | D | Date of lab: | | | | | | | | | | | | | | | |
| Ser | Serum Erythropoietin Level: ☐ ≤ 200 ☐ > 20 | | | | | | | | | | | > 20 | 0 to | 500 | | | Dat | e of | lab: | | | | | | | | | | |
| Pres | Prescriber's Signature: | | | | | | | | | | | | | Date: | | | | | | | | | | | | | | | |
| REQ | UIRE | D FOI | R RE | VIEW | : Cop | oies of | med | lical re | ecords | (i.e., | , diag | nostic | | | | | | | otes) | and th | _ | | | | | | | | |

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

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