

FLORIDA MEDICAID PRIOR AUTHORIZATION

Erythropoiesis Stimulating Agents

Clinical PA (preferred): Aranesp®/Epogen®/(Pfizer) Retacrit® Non-preferred: Mircerna®/Procrit®/(Vifor) Retacrit®

(Maximum Length of Approval = 6 Months)

Note: Form must be completed in full. An incomplete form may be returned. Recipient's Medicaid ID# Date of Birth (MM/DD/YYYY) Recipient's Full Name Prescriber's Full Name Prescriber's NPI **Prescriber's Phone Number** Prescriber's Fax Number **MEDICATION** STRENGTH: DIRECTIONS: ☐ Aranesp ☐ Mircerna Retacrit Procrit ☐ Epogen (date) INITIATION OF THERAPY -OR- CONTINUATION OF THERAPY Weight: __ kgs as of lbs or **MEDICAL HISTORY** Anemia due to renal failure? If yes, please complete the following: Yes ☐ No Acute Chronic Dialysis? Place dialysis received: ☐ Yes ☐ No Home ☐ Dialysis Center Anemia due to chemotherapy ☐ Yes ΠNο 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 □ No Is anemia due to a GI bleed? ☐ Yes ☐ Yes □ No supplements? Is patient scheduled to undergo elective, noncardiac, or nonvascular surgery and at high risk for perioperative transfusions? Yes ☐ No NOTE: Official lab reports must be submitted and dated within 2 months of the PA. Form and lab data must be completed in full. Hemoglobin Level (g/dL): Hematocrit (%): Date of lab: ___ Date of lab: Serum Ferritin ≥ 100 ng/mL: ☐ Yes ☐ No Serum Tranferrin Saturation ≥ 20% : ☐ Yes ☐ No Date of lab: Date of lab: ☐ > 200 to 500 Date of lab: _____ Serum Erythropoietin Level: **□** ≤ 200 Prescriber's Signature:

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes) and the most recent copies of related labs. The

Fax this form to 1-866-940-7328

provider must retain copies of all documentation for five years.

Pharmacy PA Call Center: 1-800-310-6826

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Date: