

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#**

[illegible]

**Date of Birth (MM/DD/YYYY)**

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**Recipient's Full Name**

[illegible]**Prescriber's Full Name**[illegible]**Prescriber's NPI**[illegible]**Prescriber's Phone Number**

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**Prescriber's Fax Number**



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**MEDICATION**

☐ Aranesp      ☐ Mircerna      ☐ Retacrit  
☐ Epogen      ☐ Procrit

**STRENGTH:**

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**DIRECTIONS:**

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Weight: \_\_\_\_\_ lbs or \_\_\_\_\_ kgs as of \_\_\_\_\_ (date)    ☐ INITIATION OF THERAPY   -OR-   ☐ CONTINUATION OF THERAPY

## MEDICAL HISTORY

<b>Anemia due to renal failure?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, please complete the following:</b>	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic
<b>Dialysis?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Place dialysis received:</b>	<input type="checkbox"/> Home <input type="checkbox"/> Dialysis Center
<b>Anemia due to chemotherapy</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is anemia due to hemolysis?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Anemia due to antiretroviral therapy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is anemia due to folate or iron deficiency?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is patient currently receiving iron supplements?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is anemia due to a GI bleed?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is patient scheduled to undergo elective, noncardiac, or nonvascular surgery and at high risk for perioperative transfusions? ☐ Yes ☐ No

**Willing to donate blood?**    ☐ 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):** \_\_\_\_\_

Date of lab: \_\_\_\_\_

**Hematocrit (%):** \_\_\_\_\_

Date of lab: \_\_\_\_\_

**Serum Ferritin  $\geq 100$  ng/mL:** ☐ Yes ☐ No

Date of lab: \_\_\_\_\_

**Serum Tranferrin Saturation  $\geq 20\%$  :** ☐ Yes ☐ No

**Date of lab:** \_\_\_\_\_

**Serum Erythropoietin Level:**    ☐  $\leq 200$                       ☐  $> 200$  to 500                      **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.**

**Mail or Fax Information to:**

Mail Stop Information to:  
Prime Therapeutics State Government Solutions LLC  
Prior Authorization  
P. O. Box 7082  
Tallahassee, FL 32314-7082  
Phone: 877-553-7481  
Fax: 877-614-1078

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