Print Form Reset Form

FLORIDA MEDICAID

Prior Authorization

Procrit®/Aranesp®

(Note: Maximum Length of Approval is 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 License # (ME, OS, ARNP, PA)

Prescriber Phone Number -

Prescriber Fax Number -

MEDICATION	STRENGTH	DIRECTIONS
○ Procrit ○ Aranesp	_____	mmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmm

Weight: _____ lbs or _____ kgs as of _____ (date) ○ **INITIATION OF THERAPY** **-OR-** ○ **CONTINUATION OF THERAPY**

MEDICAL 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? ○ Yes ○ No

Willing to donate blood? ○ Yes ○ No

NOTE: OFFICIAL LAB REPORTS MUST BE SUBMITTED AND DATED WITHIN TWO MONTHS OF THE PRIOR AUTHORIZATION REQUEST. FORM AND LAB DATA MUST BE COMPLETED IN FULL.

Hemoglobin Level (g/dL): _____ **Date of lab: _____**	**Hematocrit (%): _____** **Date of lab: _____**
Serum Ferritin ≥ 100 ng/mL : ○ **Yes** ○ **No** **Date of lab: _____**	**Serum Tranferrin Saturation ≥ 20% :** ○ **Yes** ○ **No** **Date of lab: _____**

Serum Erythropoietin Level: ○ **≤ 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), a copy of the original prescription, and the most recent copies of related labs.

The provider must retain copies of all documentation for five years.

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727