



**NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for Hematinics: Procrit/Epogen/Aranesp/Mircera/Retacrit**

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information –
Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days

Clinical Information

For Non-preferred Drugs:

Failed two preferred drugs. If only one drug is available, then failed one preferred drug.

Please List: _____

Allergic Reaction: Please provide reaction - _____

Drug-to-Drug interaction: Please list interaction - _____

Previous episode of an unacceptable side effect or therapeutic failure: _____

Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs: _____

Age-specific indications: _____

Unique clinical indication supported by FDA approval or peer-reviewed literature: _____

Unacceptable clinical risk associated with therapeutic change: _____

1. Is this new therapy? Select "Yes" for new therapy. Select "No" for continued therapy. Yes No

2. What is the diagnosis or the indication for the product?

Anemia associated with renal failure

Anemia associated with HIV infection

Anemia associated with chemotherapy

Anemia associated with myelodysplastic syndromes

Drug induced anemia such as with ribavirin or zidovudine

3. Lab test date within the past three (3) months? Date: _____ Hemoglobin: _____

4. Dosage: _____ 3b. Frequency: _____

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**