Prior Authorization Request Form for Hematopoietic Agents

Member Information
Patient Name ___________________________
Cardholder ID __________________________
Date of Birth ___________________________
Address _______________________________
City, State Zip _________________________
Phone Number___________________________

Provider Information
Provider Name ___________________________
DEANumber _______________________________
Address _________________________________
City, State and Zip ______________________
Phone Number ___________________________
FAX Number_______________________________

Pharmacy Information
Pharmacy Name___________________Address__________________Phone______________________

Name of Drug Requesting:____
Criteria for Approval:

1. Does the patient have a diagnosis of: *Check all that apply:*
   - □ anemia
   - □ anemia associated with chronic renal failure
   - □ chemotherapy-induced anemia
   - □ HIV-AZT-induced anemia
2. Has the patient been on Aranesp/Epogen/Procrit therapy for the previous 6 months? Yes ☐ No ☐
3. Is the hematopoietic agent requested to be used to treat anemia in a patient undergoing dialysis? Yes ☐ No ☐
4. Will the patient be undergoing a surgical procedure soon? Yes ☐ No ☐
5. Does the patient have uncontrolled hypertension? Yes ☐ No ☐
6. Has the patient received hematopoietic agent within the previous month? Yes ☐ No ☐
7. Is the hemoglobin of the patient >10gm/dL but ≤13gm/dL? Yes ☐ No ☐
8. Does the patient have a serum ferritin level ≥100 ng/mL and a transferring saturation ≥20%? Yes ☐ No ☐
9. Will the iron status of the patient be evaluated during therapy? Yes ☐ No ☐
10. Has the patient's hematocrit increased more than 4 points or hemoglobin increased more than 1gm/dL in any 2week period? Yes ☐ No ☐

Provider Signature____Date ___________________________

Fax completed forms to (866) 284-4509.

For Office Use Only
Date/TimeReceived____
ReferenceNumber____
Approved / Denied (Circle One) by _____________________________Date________________________
Date/Time Returned to Provider____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or Fax Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
3375-I Capital Circle NE
Tallahassee, FL 32308

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