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FLORIDA MEDICAID PRIOR AUTHORIZATION

Erythropoiesis Stimulating Agents

Clinical PA (preferred): Aranesp®/Epogen®/Retacrit™

Non-preferred: Mircerna®/Procrit®

(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 ☐ Epogen ☐ Procrit	_____	_____

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 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 ≥ 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) and the most recent copies of related labs. **The provider must retain copies of all documentation for five years.**

Mail or Fax Information to:
Magellan Medicaid Administration, Inc.
Prior Authorization
P. O. Box 7082
Tallahassee, FL 32314-7082
Phone: 877-553-7481
Fax: 877-614-1078

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