

## 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:*
- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> anemia                      | <input type="checkbox"/> anemia associated with chronic renal failure |  |  |
| <input type="checkbox"/> chemotherapy-induced anemia | <input type="checkbox"/> 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 transferrin 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/Time Received \_\_\_\_\_  
 Reference Number \_\_\_\_\_  
 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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