| United | | | | FLOF | RIDA | A ME | DIC | CAID | PF | RIOF | R AL | JTH | IOR | IZA | | Ν | | | | | |
|--|------------|--|---------|---------|---|---|------|--|------|--------|--------|-------|--------|-------------------|-------|--------|-----|--|---------------|--|----------|
| Healthcare | | | | | - | - | | esis | | - | | - | | | | | | | _ | | |
| Community Pla | | Clinical PA (preferred): Aranesp [®] /Epogen [®] /(Pfizer) Retacrit [®] | | | | | | | | | | | | | | | | | | | |
| Non-preferred: Mircerna®/Procrit®/(Vitor) Retacrit® | | | | | | | | | | | | | | | | | | | | | |
| | | | loto: | Form | | (Maximum Length of Approval = 6 Months) st be completed in full. An incomplete form may be returned. | | | | | | | | | | | | | | | |
| Desirientis Mediacid ID# | | | iote. | | | | | | | | looni | Jiele | 101111 | may | | eturri | eu. | | | | |
| Recipient's Medicaid ID# | | | | | | | | e of Birth (MM/DD/YYYY) | | | | | | | | | | | | | |
| | | | | | | / | | | / | | | | | | | | | | | | |
| Recipient's Full Name | <u> </u> | | | ΤΤ | | | T | | | T | 1 | | | | 1 | | [| | | | <u> </u> |
| | | | | | | | | | | | | | | | | | | | | | |
| Prescriber's Full Name | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| Prescriber's NPI | | | | | | | | | | | | | | | | | | | | | |
| | | |] | | | | | | | | | | | | | | | | | | |
| Prescriber's Phone Number | | Prescriber's Fax Number | | | | | | | | | | | | | | | | | | | |
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| | | | SI | | тн∙ | | | DIRE | | NS | | | | | | 1 | 1 | | | | |
| Aranesp Mircerna | 🗌 Ret | acrit | | | | | | | | | | | | | | | | | | | |
| | | | | | | (1.1.1.) | | | ATIC | | | | | | | ONTI | | | ог т і | | |
| Weight: Ibs 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 Cen | | | | | nter | | |
| 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 ele | ctive, n | oncard | liac, e | or nonv | ascul | ar sur | gery | and at | high | n risk | for pe | eriop | erativ | ve tra | nsfus | ions | ? | | Yes | |] No |
| Willing to donate blood? | N | 0 | | | | | | | | | | | | | | | | | | | |
| 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): | | | | | | | | Hematocrit (%): | | | | | | | | | | | | | |
| Date of lab: | | Date of lab: | | | | | | | | | | | | | | | | | | | |
| Serum Ferritin ≥ 100 ng/mL: ☐ Yes ☐ No | | | | | | | | Serum Tranferrin Saturation ≥ 20% : ☐ Yes ☐ No | | | | | | | | | | | | | |
| Date of lab: | | | | | | | | ab: | | | | | | | | | | | | | |
| Serum Erythropoietin Level: | □≤ | 200 | | □> | 200 | to 50 | 0 | | Da | te 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.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center: 1-800-310-6826

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