

ARANESP, EPOGEN, PROCRT

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date			
SECTION A - PATIENT INFORMATION			
First Name:		Last Name:	Member ID:
Address:			
City:		State:	Zip:
Phone:		DOB:	Allergies:
Primary Insurance:		Policy #:	Group #:
<p>Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/>? If so, start date: _____</p> <p>Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
SECTION B - PHYSICIAN INFORMATION			
First Name:		Last Name:	M.D./D.O.
Address:		City:	State: Zip:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			
<p>Medication to be Administered: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home</p>			
<p>Deliver Rx to: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other Address: _____</p> <p style="padding-left: 40px;"><input type="checkbox"/> Patient's Home _____</p>			
SECTION C - MEDICAL INFORMATION			
Medication:		Strength:	
Directions for use:			
Diagnosis (Please be specific & provide as much information as possible):			ICD-9 CODE:
<ul style="list-style-type: none"> What is the patient's diagnosis? <i>(Please provide ICD-9 code above)</i> Is the patient currently receiving chemotherapy? Has the patient received treatment with erythropoietin in the past 3 months? Is this a new prescription for the patient or a continuation of existing therapy? What is the patient's current hemoglobin AND hematocrit results? <i>Please provide results below.</i> List hemoglobin and the date of the result: _____ g/dl List hematocrit and the date of the result: _____ % Is the patient's hemoglobin and hematocrit being monitored at regular intervals? List monitoring frequency if available: _____ Is the patient currently receiving iron supplementation? Has the patient's iron stores been evaluated? Did the results indicate that the patient's iron stores are below the normal range? (Transferrin saturation ≤ 20% and ferritin is ≤ 100ng/ml). <i>Please provide results below.</i> Transferrin saturation: _____ % Ferritin: _____ ng/ml 			
Physician Signature: _____			Date: _____

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