



## NC DMA Pharmacy Request for Prior Approval - Procrit/Epogen/Aranesp



### Recipient Information

DMA-0020 (V.01)

1. Recipient Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Recipient ID #: \_\_\_\_\_ 4. Recipient Date of Birth: \_\_\_\_\_ 5. Recipient Gender: \_\_\_\_\_

### Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid:  Health Choice:

### Prescriber Information

7. Prescribing Provider #: \_\_\_\_\_ NPI:  or Atypical:

8. Prescriber DEA #: \_\_\_\_\_

#### Requester Contact Information

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

### Drug Information

9. Drug Name:  Procrit  Epogen  Aranesp 10. Strength: \_\_\_\_\_ 11. Quantity Per 30 Days: \_\_\_\_\_

12. Length of Therapy (in days):  up to 30  60  90  120  180  Other: \_\_\_\_\_

### Clinical Information

1. What is the diagnosis or the indication for the product:

- a. Anemia associated with renal failure
- b. Anemia associated with HIV infection
- c. Anemia associated with chemotherapy
- d. Anemia associated with myelodysplastic syndromes
- e. Drug induced anemia such as with ribavirin or zidovudine

2a. Is this new therapy  or 2b. Continuation of therapy

3. Lab test date (dated within the last 3 months): \_\_\_\_\_ Hemoglobin: \_\_\_\_\_ g/dl

4. What is the dosage and frequency of dosing? \_\_\_\_\_

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

\*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSC at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505