NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for

Hematinics: Procrit/Epogen/Aranesp/Mircera/Retacrit

Beneficiary Information

1. Beneficiary Last Name: ________________________ 2. First Name: ____________________________________
3. Beneficiary ID #: ________________ 4. Beneficiary Date of Birth: ________________ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: ____
7. Requester Contact Information - Name: ________________________ Phone #: ___________________ Ext. ____

Drug Information

8. Drug Name: __________________________ 9. Strength: ______________ 10. Quantity Per 30 Days: _______
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

For Non-preferred Drugs:
☐ Failed two preferred drugs. If only one drug is available, then failed one preferred drug.
Please List: ____
☐ Allergic Reaction: Please provide reaction - ____
☐ Drug-to-Drug interaction: Please list interaction - ____
☐ Previous episode of an unacceptable side effect or therapeutic failure: _________________________________
☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred Drugs: ____
☐ Age specific indications: ____
☐ Unique clinical indication supported by FDA approval or peer reviewed literature: _________________________
☐ Unacceptable clinical risk associated with therapeutic change: ______________________________________

1. Is this new therapy? Select "Yes" for new therapy. Select "No" for continued therapy. ☐ **Yes** ☐ **No**
2. What is the diagnosis or the indication for the product?
   - ☐ Anemia associated with renal failure
   - ☐ Anemia associated with HIV infection
   - ☐ Anemia associated with chemotherapy
   - ☐ Anemia associated with myelodysplastic syndromes
   - ☐ Drug induced anemia such as with ribavirin or zidovudine
   - ☐ Sickle Cell Disease
3. Lab Test Date Within the Last 3 Months? Date: ____________ Hemoglobin: _____________
4. Dosage: _______________ 3b. Frequency: _____________________

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 CSRA at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505