



**NC DHB Pharmacy Request for Prior Approval
Procrit/Epogen/Aranesp/Mircera/Retacrit**

Recipient Information

DMA-0020 (V.02)

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

Prescriber Information

7. Prescribing Provider #: _____	NPI: <input type="checkbox"/> or Atypical: <input type="checkbox"/>
8. Requester Contact Information	
Name: _____	Phone #: _____ Ext: _____

Drug Information

9. Drug Name: _____	10. Strength: _____	11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): <input type="checkbox"/> up to 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> 180 <input type="checkbox"/> Other: _____		

Clinical Information

<p>1. What is the diagnosis or the indication for the product?</p> <p>a. _____ Anemia associated with renal failure</p> <p>b. _____ Anemia associated with HIV infection</p> <p>c. _____ Anemia associated with chemotherapy</p> <p>d. _____ Anemia associated with myelodysplastic syndromes</p> <p>e. _____ Drug induced anemia such as with ribavirin or zidovudine</p> <p>2a. Is this request for a non-preferred drug? _____ Yes _____ No</p> <p>2b. For non-preferred requests please list preferreds tried. _____</p> <hr/> <p>2c. If beneficiary is unable to use the preferreds, please list clinical reasons. _____</p> <hr/> <p>3a. Is this new therapy? _____ Yes _____ No or 3b. Continuation of therapy? _____ Yes _____ No</p> <p>4. Lab test date (dated within the last 3 months): _____ Hemoglobin: _____ g/dl</p>
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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 NCTracks at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505