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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa)

Prior Authorization of Benefits Form

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information	**2. Physician information**
Patient name: ______	Prescribing physician: ______
Patient ID #: ______	Physician address: ______
Patient DOB: ______	Physician phone #: ______
Date of Rx: ______	Physician fax #: ______
Patient phone #: ______	Physician specialty: ______
Patient email address: ______	Physician DEA: ______
	Physician NPI #: ______
	Physician email address: ______

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
☐ Epogen (epoetin alfa) ☐ Procrit (epoetin alfa) ☐ Retacrit (epoetin alfa)	______	______	Specify: ______

7. Diagnosis: ______

8. Approval criteria: (Check all boxes that apply. **Note:** Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

- ☐ Yes ☐ No Patient has a diagnosis of chronic renal failure in the last 730 days.
- ☐ Yes ☐ No Patient has a diagnosis of cancer in the last 730 days.
- ☐ Yes ☐ No Patient has a history of HIV in the last 730 days.
- ☐ Yes ☐ No Patient has a history of an antineoplastic agent in the last 30 days.
- ☐ Yes ☐ No Patient has a history of chemotherapy in the last 30 days.
- ☐ Yes ☐ No Patient has a history of zidovudine in the last 90 days.
- ☐ Yes ☐ No Patient has a history of an ESA in the last 90 days.
- ☐ Yes ☐ No Patient has a history of a complete blood count (CBC) in the last 90 days.
- ☐ Yes ☐ No Patient has a history of ferritin and iron binding capacity (IBC) tests in the last 180 days.

9. Physician signature

______ ______
Prescriber or authorized signature Date

Prior authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

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