



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

Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 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

			Specify:
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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.)

<input type="checkbox"/>	<input type="checkbox"/>	Patient has a diagnosis of chronic renal failure in the last 730 days.
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a diagnosis of cancer in the last 730 days.
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a history of HIV in the last 730 days.
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a history of an antineoplastic agent in the last 30 days.
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a history of chemotherapy in the last 30 days.
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a history of zidovudine in the last 90 days.
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a history of an ESA in the last 90 days.
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a history of a complete blood count (CBC) in the last 90 days.
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a history of ferritin and iron binding capacity (IBC) tests in the last 180 days.
<input type="checkbox"/>	<input type="checkbox"/>	Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a documented allergy or contraindication to preferred agents in this class.
<input type="checkbox"/>	<input type="checkbox"/>	Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the Texas Medicaid *Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at <http://www.txvendordrug.com/formulary/formulary-search.asp>.

9. Physician signature

_____ Prescriber or authorized signature	_____ Date
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<https://provider.amerigroup.com>

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

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.

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