



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/complecare-forproviders/pharmacy

Erythropoiesis Stimulating Agents Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information									
Member Name (first & last):			Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Height:		
Member ID:			City:		State:		Weight:		
Prescribing Provider Information									
Provider Name (first & last):			Specialty:		NPI#		DEA#		
Office Address:			City:		State:		Zip Code:		
Office Contact:				Office Phone			Office Fax:		
Dispensing Pharmacy Information									
Pharmacy Name:				Pharmacy Phone:			Pharmacy Fax:		
Requested Medication Information									
Preferred Agent:			<input type="checkbox"/> Retacrit						
Non-Preferred Agents:	<input type="checkbox"/> Epogen	<input type="checkbox"/> Procrit	<input type="checkbox"/> Aranesp	<input type="checkbox"/> Mircera	<input type="checkbox"/> Other, please specify:				
For non-preferred agents ONLY: Did member have trial and failure with Retacrit?								<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any contraindications to formulary medications? If yes, please specify:				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy request		
ICD-10 Code:		Diagnosis:		Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes No					
Directions for Use:			Strength:			Dosage Form:			
			Quantity:		Day Supply:	Duration of Therapy/Use:			
Turn-Around Time for Review									
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> Urgent – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____						
Clinical Information									
Does member have uncontrolled HTN?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is reticulocyte Hgb content >29 pg?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is serum ferritin ≥100 ng/mL AND transferrin saturation (iron saturation) ≥20%?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Additional Criteria Based on Indication									
<input type="checkbox"/> Anemia due to Chronic Kidney Disease									
Is Hgb <10 g/dL within the last 2 weeks?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Renewal Request ONLY									
Is member an ADULT on HD with Hgb <11 g/dL within last 2 weeks?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member an ADULT NOT on HD with Hgb <10 g/dL within last 2 weeks?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is member a PEDIATRIC with Hgb <12 g/dL within last 2 weeks?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Anemia due to Cancer Chemotherapy									
Is anemia due to concomitant myelosuppressive chemotherapy?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is diagnosis non-myeloid malignancy such as solid tumor AND expected outcome is			<input type="checkbox"/> Yes	<input type="checkbox"/> No

			not a cure?		
Is there a minimum of TWO additional months of planned chemotherapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was Hgb <10 g/dL within last 2 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Request ONLY					
Is Hgb <11 g/dL within last 2 weeks?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Anemia with HIV Member Receiving Zidovudine					
Is Zidovudine dose ≤4200 mg/week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are erythropoietin levels ≤ 500 IU/L?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was Hgb <10 g/dL within the last 2 weeks?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY					
Was Hgb <11 g/dL within the last 2 weeks?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Reducing Transfusions in Elective Non-Cardiac Non-Vascular Surgery					
Was Hgb >10 g/dL AND ≤13 g/dL within 30 days prior to planned surgery date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member at high risk for perioperative blood loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is member unable or unwilling to donate autologous blood preoperatively?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Anemia Associated with Myelodysplastic Syndrome					
Are recent erythropoietin levels ≤500 IU/L?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was Hgb <10 g/dL within last 2 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Request ONLY					
Was hemoglobin <12 g/dL within last 2 weeks?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Anemia in Hepatitis C					
Is member receiving combination therapy with ribavirin AND interferon alpha?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was Hgb <12 g/dL within last 2 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.					

Signature affirms that information given on this form is true and accurate and reflects office notes.	
Prescribing Provider's Signature: _____	Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.