MERCYCARE HEALTH PLANS

PRIOR AUTHORIZATION FAX REQUEST FORM **- FAX to 608-758-7726**

FOR **Hematopoietic Agents (Procrit, Epogen, Aranesp)**

Name	DOB
MercyCare ID#	

NOTICE: This form is to be used for**:**
Prior Approval of Procrit, Epogen, Aranesp

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Primary Plan: *Tier 2 3 4*

Secondary Plan:

Transaction #

Drug Name:	Strength:	Dosing:	Quantity:
		Duration of Therapy:	

Please check the appropriate boxes and send supporting documentation. Patients will be approved for a hematopoietic agent if they meet the following criteria. **Usage compatible with the FDA approval.**

- ❑ New therapy
- ❑ Continuation of previously approved MercyCare override
- ❑ Continuation of therapy authorized by previous insurance

Chemotherapy-Induced Anemia

Hematopoietics are indicated to decrease the need for transfusions in patients who are receiving concomitant chemotherapy for a minimum of 2 months. Procrit and Epogen are preferred agents.

- ❑ Malignancy indication other than myeloid malignancy
- ❑ Myelosuppressive chemotherapy is planned for a minimum of 2 months
- ❑ Hemoglobin is <10 g/dL
- ❑ Trial of Procrit or Epogen required before Aranesp

Method of Administration

- ❑ Self-injection at home
- ❑ Administration at clinic

Prescriber Signature:	Date	Phone #	Fax #
Prescriber Name (Please Print)	Specialty	Location	

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Approved for: / / ***to*** / /

3—6—9—12 months

Benefit type: Pharmacy—Medical

Denied

D2—D6

Redirect

File

Pharmacist Signature: _____ **Date:** _____