UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for

Hematinics: Procrit/Epogen/Aranesp/Mircera/Retacrit

Beneficiary Information

1. Beneficiary Last Name: ______________________ 2. First Name: _________________________________
3. Beneficiary ID #: ______________ 4. Beneficiary Date of Birth: ______________ 5. Beneficiary Gender: ___

Prescriber Information

6. Prescribing Provider NPI #: ____
7. Requester Contact Information - Name: ______________________ Phone #: __________________ Ext. ____

Drug Information

8. Drug Name: _________________________ 9. Strength: _____________ 10. Quantity Per 30 Days: ______
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

For Non-preferred Drugs:

☐ Failed two preferred drugs. If only one drug is available, then failed one preferred drug.
Please List: ____

☐ Allergic Reaction: Please provide reaction - ____

☐ Drug-to-Drug interaction: Please list interaction - ____

☐ Previous episode of an unacceptable side effect or therapeutic failure: _______________________________

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred Drugs: ____

☐ Age specific indications: ____

☐ Unique clinical indication supported by FDA approval or peer reviewed literature: ________________________

☐ Unacceptable clinical risk associated with therapeutic change: ___________________________________

1. Is this new therapy? Select "Yes" for new therapy. Select "No" for continued therapy. ☐ **Yes** ☐ **No**
2. What is the diagnosis or the indication for the product?
   - ☐ Anemia associated with renal failure
   - ☐ Anemia associated with HIV infection
   - ☐ Anemia associated with chemotherapy
   - ☐ Anemia associated with myelodysplastic syndromes
   - ☐ Drug induced anemia such as with ribavirin or zidovudine
3. Lab Test Date Within the Last 3 Months? Date: __________ Hemoglobin: ___________
4. Dosage: ______________ 3b. Frequency: ____________________

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 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593