Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Hematopoietic/Hematinic Agents Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the indication for use below:

- ❑ Treatment of anemia secondary to myelosuppressive anticancer chemotherapy
- ❑ Treatment of anemia related to zidovudine therapy in HIV-infected patients
- ❑ Treatment of anemia secondary to end stage renal disease (ESRD)
- ❑ Reduction of the need for allogenic transfusions in surgery patients when significant blood loss is anticipated
- ❑ Other indication for use: _____

ICD-10 Code(s): _____

Clinical information:

Will hemoglobin levels be achieved and maintained within the range of 10 to 12 gm/dL (or 10 to 13 gm/dL when used for reduction of the need for allogenic transfusions in surgery patients)? ❑ **Yes** ❑ **No**

Has the recipient been evaluated for adequate iron stores? ❑ **Yes** ❑ **No**

Will recent laboratory results of the member's serum hemoglobin within seven days of the request be included with the prior authorization request? ❑ **Yes** ❑ **No**

If no, please explain: _____

Please attach recent laboratory documentation to the prior authorization request

Clinical Information Cont. (required)

For Epogen®, Mircera® or Procrit® requests, also answer the following:

Has the member experienced therapeutic failure of TWO different preferred medications within the same drug class? ❑ **Yes** ❑ **No**

If **yes,** please list medications: _____

Does the member have an allergy, contraindication, drug-to-drug interaction, or a history of unacceptable/toxic side effects with ALL preferred medications within the same drug class? ❑ **Yes** ❑ **No**

If **yes**, please list ALL medications and response: _____

_____

Is the non-preferred medication being requested because it is being used for a unique indication that is supported by peer-reviewed literature or an FDA-approved indication? ❑ **Yes** ❑ **No**

If **yes**, please list the unique indication: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.