Print Form



Aetna Better Health® of Florida (MEDICAID)

Erythropoiesis Stimulating Agents

Clinical PA (preferred): Aranesp®/ Epogen®/(Pfizer)Retacrit®

Non-preferred: Mircerna[®]/Procrit[®]/(Vifor)Retacrit[®] (Maximum Length of Approval = 6 Months)

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID# Date of												of Birth (MM/DD/YYYY)																		
														/			/													
Rec	ipien	l t's F	ull N	ame	<u> </u>									_			j					J								
Prescriber's Full Name										l	1	1	1	l	1									I		1				
Prescriber's NPI								1	7	ı	1	1	1	ı	1									ı						
Prescriber's Phone Number													Prescriber's Fax Number																	
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]																							
	MEDICATION STRENGTH: ☐ Aranesp ☐ Mircerna ☐ Retacrit												:			DIREC	TION	IS:												
Epogen Procrit																														
Weight: lbs or kgs as of											(d	(date) INITIATION OF THERAPY -OR- CONTINUATION											ION	OF TI	HERA	\PY				
MEDICAL HISTORY																														
Ane	Anemia due to renal failure?											If	yes,	pleas	se cor	nplet	e the	Acute Chronic												
Dial	Dialysis?												Р	lace o	dialys	sis re	ceive	d:			☐ Home ☐ Dialysis Center									
Ane	Anemia due to chemotherapy												Is	aner	nia d	ue to	hem	olysis	s?		☐ Yes ☐ No									
Ane	Anemia due to antiretroviral therapy?													aner	nia d	ue to	folat	e or i	ron d	,	☐ Yes ☐ No									
	Is patient currently receiving iron Yes No supplements?												Is	Is anemia due to a GI bleed?										☐ Yes ☐ No						
Is patient scheduled to undergo elective, noncardiac, or nonvascular surgery and at high risk for perioperative transfusions?] No															
Willing to donate blood?																														
NOTE: Official lab reports must be submitted and dated within 2 months of the PA. Form and lab data must be completed in full.																														
Hen	Hemoglobin Level (g/dL):													Hematocrit (%):																
Dat	Date of lab:													Date of lab:																
Ser														Serum Tranferrin Saturation ≥ 20% :																
Dat	Date of lab: D														Date of lab:															
Ser	Serum Erythropoietin Level:																													
Dros	Praecribar's Signatura																				Da	to:								
Prescriber's Signature: Date:																														
prov	ider n	nust	retair	1 сор	ies o	f all d	locur	nenta	tion	for fiv	ve ye	ars.																		

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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