NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

# NC DHB Pharmacy Request for Prior Approval
# Procrit/Epogen/Aranesp

**Recipient Information** **DMA-0020 (V.01)**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

**Payer Information**

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

**Prescriber Information**

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

**Drug Information**

9. Drug Name: ☐ Procrit ☐ Epogen ☐Aranesp 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐Other:_____

**Clinical Information**

1. What is the diagnosis or the indication for the product:
☐ a. Anemia associated with renal failure
☐ b. Anemia associated with HIV infection
☐ c. Anemia associated with chemotherapy
☐ d. Anemia associated with myelodysplastic syndromes
☐ e. Drug induced anemia such as with ribavirin or zidovudine
2a. Is this new therapy ☐ or 2b. Continuation of therapy ☐
3. Lab test date (dated within the last 3 months): _____ Hemoglobin: _____g/dl
4. What is the dosage and frequency of dosing? _____

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: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**