



Hematopoietic Agents Erythropoiesis Stimulating Agents – Washington

Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: New or Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? Yes No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have any of the following diagnoses? <i>(If yes, check all that apply)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia Due to Chronic Kidney Disease (CKD) <input type="checkbox"/> Anemia of prematurity <input type="checkbox"/> Anemia Associated with Zidovudine-Treated HIV-Infected Patients <input type="checkbox"/> Anemia of Cancer Patients on Chemotherapy, where the intent of treatment is palliative <input type="checkbox"/> Anemia Associated with Myelodysplastic Syndrome to Reduce Transfusion Dependency <input type="checkbox"/> Anemia After Allogeneic Bone Marrow Transplantation <input type="checkbox"/> Anemia due to Ribavirin in Patients who did not experience an improvement in Hemoglobin level with Ribavirin dose reduction <input type="checkbox"/> To reduce the need for blood transfusions in anemic participants scheduled to undergo high-risk surgery who are at increased risk or intolerant to transfusions <input type="checkbox"/> Special circumstance patients who will not or cannot receive whole blood or components as replacement for traumatic or surgical loss
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List patient's most recent hemoglobin level: _____ g/dL

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Did the patient have an inadequate response or documented intolerance due to severe adverse reaction or contraindication to at least two preferred agents? <i>(If yes, complete Section D above)</i></p>
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ANEMIA DUE TO CHRONIC KIDNEY DISEASE (CKD)

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is there documentation of adequate iron stores as indicated by current (within the last 3 months) serum ferritin level greater than or equal to 100 mcg/L or serum transferrin saturation greater than or equal to 20%? <i>If yes, list serum ferritin and/or serum transferrin:</i></p>
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ANEMIA OF PREMATUREITY

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is there documentation of refusal of transfusion due to religious or cultural reasons?</p>
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CONTINUATION OF THERAPY

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is there documentation of positive clinical response (e.g., as evidenced by decrease in blood transfusions) submitted by the prescriber?</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is there documentation of positive clinical response submitted by the prescriber?</p>

Provider Signature: _____ **Date:** _____

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