



**Procrit**  
(epoetin alfa)

**Prior Authorization Form**  
**Curascript**  
**Fax (888) 773-7386**

Last Name		First Name		Prescriber's Name		Specialty	
Home Phone		Work Phone		Office Phone		Office Fax	
Home Address		City	State	ZIP	Address		City State ZIP
VH ID number		Date of Birth		Est. Start Date		Office Contact	
<b>For Specialty Medications Only:</b> Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home				Special Instructions (i.e. Non-English Speaking Patient, etc.):			

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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<p><b>1. Is the diagnosis or indication one of the following? <i>Must be indicated.</i></b></p> <p><input type="checkbox"/> Anemia associated with chronic kidney disease</p> <p><input type="checkbox"/> Chemotherapy induced anemia (nonmyeloid)</p> <p><input type="checkbox"/> Anemia related to zidovudine-treatment in HIV-infected patient</p> <p><input type="checkbox"/> Prevention of allogeneic blood transfusion in patients scheduled to undergo noncardiac, nonvascular surgery</p>
<p><b>2. Is the patient on dialysis?</b></p>
<p><b>3. What are the patient's serum creatinine level, creatinine clearance, and weight?</b></p>
<p><b>4. Is the patient iron deficient?</b></p>
<p><b>5. Is the patient not currently being treated for this deficiency?</b></p>
<p><b>6. Is antithrombotic prophylaxis considered? (applicable to the following diagnosis: Prevention of allogeneic blood transfusion in patients scheduled to undergo noncardiac, nonvascular surgery)</b></p>
<p><b>7. What is the pretreatment endogenous erythropoietin level? (applicable to the following diagnosis: Anemia related to zidovudine-treatment in HIV-infected patient).</b></p>
<p><b>8. What is the patient's target hemoglobin level?</b></p>
<p><b>9. Does the patient have a diagnosis of uncontrolled hypertension?</b></p>
<p><b>10. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?</b></p>

Physician's Signature: \_\_\_\_\_ NPI/DEA #: \_\_\_\_\_ Date: \_\_\_\_\_

<p><u>For Internal Use Only</u></p> <p><input type="checkbox"/> Approved <input type="checkbox"/> Denied</p> <p>Reviewer's Initials _____ Decision Date _____</p> <p>Comments _____</p>
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