

**Pharmacy Prior Authorization Form – Procrit****Fax Completed Form to (800) 314-6223**PA forms and guidelines are available on the provider portal of www.healthnet.comIf the fax number provided is not a dedicated machine to you or your staff, please check this box ☐**FORM MUST BE FULLY COMPLETED TO PROCESS PRIOR AUTHORIZATION REQUEST. PLEASE PRINT CLEARLY.**

Patient's Name (Last, First, MI):										Date of Birth (Month, Day, Year):														
Patient's ID Number:										Patient's Phone Number:														
Physician's Name:										Physician's Specialty:														
Are you the patient's primary care physician? <input type="checkbox"/> YES <input type="checkbox"/> NO																								
Physicians Phone Number (Please print clearly):										Physician's Fax Number (Please print clearly):														
() ---										() ---														
Pharmacy's Phone Number (Please print clearly):										Pharmacy's Fax Number (Please print clearly):														
() ---										() ---														
Date Medication Needed:																								
Diagnosis:										ICD-9 Code:														
Medication:					Strength:					Directions:					Qty/Mth:					Duration:				
<input type="checkbox"/> Procrit*																								
<input type="checkbox"/>																								
Administered: <input type="checkbox"/> Doctor's Office <input type="checkbox"/> In Dialysis Center <input type="checkbox"/> By Patient <input type="checkbox"/> Other: _____																								

* Procrit is preferred over Epogen and Aranesp

Please attach documentation to support the following:			
1. Is this for initiation of treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, is dose being increased?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Hct & Hgb levels:	Current: Hct _____ % Hgb _____ gm/dL Date: _____	Previous: Hct _____ % Hgb _____ gm/dL Date: _____	
3. Does patient have adequate iron stores (transferrin saturation \geq 20% & serum ferritin \geq 100 ng/ml)?	<input type="checkbox"/> YES <input type="checkbox"/> NO Please attach labs.		
4. Is patient currently receiving supplemental iron?	<input type="checkbox"/> YES <input type="checkbox"/> NO		

I certify that the above information is correct to the best of my knowledge and that I will be supervising the treatment accordingly. I further authorize administration of supplies (syringes, needles) related to therapy.

Physician's Signature _____

Date _____

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Where applicable this prescription will be forwarded by Health Net to Accredo (Formerly known as Curascript) Pharmacy for delivery to the patient. Accredo may be contacted at (888) 773-7376.