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.com

If 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? ☐ YES ☐ 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:**
☐ Procrit*				
☐				

Administered: ☐ Doctor's Office ☐ In Dialysis Center ☐ By Patient ☐ Other: _____

* Procrit is preferred over Epogen and Aranesp

Please attach documentation to support the following:

1. Is this for initiation of treatment? ☐ YES ☐ NO If no, is dose being increased? ☐ YES ☐ 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 ≥ 20% & serum ferritin ≥ 100 ng/ml)?
   ☐ YES ☐ NO *Please attach labs.*
4. Is patient currently receiving supplemental iron? ☐ YES ☐ 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 _____

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.