Nevada Medicaid – Molina Healthcare

Hematopoietic/Hematinic Agents

Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request**. Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Molina ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the indication for use below:

❑ Treatment of anemia secondary to myelosuppressive anticancer chemotherapy

❑ Treatment of anemia related to zidovudine therapy in HIV-infected patients

❑ Treatment of anemia secondary to end stage renal disease (ESRD)

❑ Reduction of the need for allogenic transfusions in surgery patients when significant blood loss is anticipated

❑ Other indication for use: ______________________________

ICD-10 Code(s): ______________________________

Clinical information:

Will hemoglobin levels be achieved and maintained within the range of 10 to 12 gm/dL (or 10 to 13 gm/dL when used for reduction of the need for allogenic transfusions in surgery patients)? ❑ **Yes** ❑ **No**

Has the recipient been evaluated for adequate iron stores? ❑ **Yes** ❑ **No**

Will recent laboratory results of the member's serum hemoglobin within seven days of the request be included with the prior authorization request? ❑ **Yes** ❑ **No**

If no, please explain: ______________________________

Please attach recent laboratory documentation to the prior authorization request

Clinical Information Cont. (required)

For Epogen®, Mircera® or Procrit® requests, also answer the following:

Has the member experienced therapeutic failure of TWO different preferred medications within the same drug class? ❑ **Yes** ❑ **No**

If **yes,** please list medications: ____________________

Does the member have an allergy, contraindication, drug-to-drug interaction, or a history of unacceptable/toxic side effects with ALL preferred medications within the same drug class? ❑ **Yes** ❑ **No**

If **yes**, please list ALL medications and response: ____________________

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Is the non-preferred medication being requested because it is being used for a unique indication that is supported by peer-reviewed literature or an FDA-approved indication? ❑ **Yes** ❑ **No**

If **yes**, please list the unique indication: ____________________

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call (833) 685-2103.
This form may be used for non-urgent requests and faxed to (844) 259-1689.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Molina Healthcare. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**