

**Physician's Prior Authorization Questionnaire  
Epogen®/Procrit® (Erythropoietin)**

**Patient:**

**ID#:**

**DOB:**

**Patient Address:**

Epogen®/Procrit® (Erythropoietin) is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's complete diagnosis? *(Please do not use codes.)* \_\_\_\_\_  
\_\_\_\_\_
2. This patient requires Epogen®/Procrit® for anemia associated with the following reason(s):
  - AIDS;
  - Anemia of Chronic Disease;
  - Bcell Malignancy;
  - Induced by cancer chemotherapy for non-myeloid malignancies.
  - Multiple Myeloma;
  - Myelofibrosis;  
*Erythropoietin Level:* \_\_\_\_\_
  - Myeloplasic Anemia;
  - Prematurity;
  - Reducing allogeneic blood transfusions in anemic patients who are scheduled to undergo elective, non-cardiac, non-vascular surgery.
  - Renal Disease;
  - Rheumatoid Arthritis;
  - Sideroblastic Anemia;
3. Is this patient symptomatic?  Yes  No  
*Hematocrit (%):* \_\_\_\_\_ *Hemoglobin:* \_\_\_\_\_
4. If this is not the initial treatment, has patient responded to treatment with Epogen®/Procrit®?  Yes  No
5. Is this medication being provided and administered in your office?  Yes  No
6. How long do you anticipate this therapy to last? \_\_\_\_\_

***If patient administered, Epogen®/Procrit® will be shipped to the patient by our Specialty Pharmacy.***

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please **Print** Physician's Name & Specialty

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

**Forms are also available online at [www.usableadmin.com/providers/PharmacyForms.aspx](http://www.usableadmin.com/providers/PharmacyForms.aspx)**