State of Oklahoma
Oklahoma Health Care Authority
Erythropoietin Stimulating Agents Prior Authorization Request

SoonerSelect | aetna

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Medication Name: _____ ***Strength:*** _____

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

☐ ***Physician billing: HCPCS code:*** _____ ***Billing units:*** _____

☐ ***Pharmacy billing: NDC:*** _____ ***Fill Quantity:*** _____ ***Day Supply:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____

Criteria

Diagnosis: _____ ***ICD:*** _____

Hb: _____ ***g/dL or Hct:*** _____ ***%*** ***Date Recorded:*** _____

Is the member on dialysis? Yes ☐ ***No*** ☐

Additional Information: _____

_____

Prescriber Signature: _____ ***Date:*** _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

OHCA Approved – 6/6/2018