

Bluegrass Family Health
Medication Pre-Certification Request for **Aranesp, Procrit, or Epogen**
Phone: 877-205-6308
Fax: 859-335-3744

Instructions: This form is to be used by participating physicians and providers to request approval for medications requiring a PA. Approval is based on medical necessity criteria established by the Bluegrass Family Health's Pharmacy and Therapeutics Committee. Please complete this form in detail and fax to 859-335-3744. **Requests lacking pertinent information will be denied pending additional information. For this reason, office notes may be required.**

MEMBER INFO:

Name: _____ ID Number: _____ DOB: _____

Diagnosis **and Code**: _____

Drug Requested: _____ Strength _____ **JCODE** _____

Length of Treatment: _____ Quantity: _____ Dosage Form: Oral / Injection / Topical

✧ Hematocrit Level: _____ Hemoglobin Level: _____

Medication History including medications tried and failed (please include strength and dose of each): _____

Other Pertinent History: _____

PROVIDER INFO:

Will the doctor be providing this medication? YES / NO

Will this be administered at the provider office? YES / NO

Physician Name and Specialty: _____

DEA# _____ Contact Person (Please Print): _____

Telephone Number _____ Fax Number _____

Signature of Contact Person: _____

BFH USE ONLY:

Request was: Approved Qty approved: _____ Denied Pending More Info

Specialist Initials: _____ Start Date: _____ Expiration Date: _____

Comments: _____