RYAN WHITE PROGRAM
Prior Authorization Form for Procrit® or Epogen® (both Epoetin Alpha)

Recipient's Full Name:_______________________ Date of Birth: _______ /_______ /_____________
Prescriber Full Name:__________________________ Prescriber License #: (ME,OS,RN)____________
Prescriber Telephone #:________________________ Prescriber Fax #:__________________________
Drug Strength: ______________________________

Please check below the diagnosis or indication for this product:

□ Anemia associated with HIV
□ Anemia associated with renal failure if patient is not on dialysis
□ Anemia associated with chemotherapy
□ Other __________________________

Select one of the following:

New Therapy □ **OR** Continuation of Therapy □

Does the patient have active gastrointestinal bleeding? □ YES **OR** □ NO

Lab Test Date:____________ Hematocrit:__________% Hemoglobin:________g/dl

Indicate dosage and frequency of dosing: ____

Prescriber's Signature: ____

Please attach a copy of the original prescription and lab results dated within the last two (2) months.

Fax information to:

Ryan White Program-funded Pharmacy	Phone Number	Fax Number
AIDS Healthcare Foundation	(305) 758-1984	(305) 758-8714
Citrus Health Network	(305) 825-0300, Ext. 2770	(305) 556-2580
Community Health of South Dade (Doris Ison)	(305) 253-5100	(305) 254-7795
Community Health of South Dade (MLKJCC)	(305) 248-4334	(305) 246-1016
Mercy Professional Pharmacy	(305) 285-2762	(305) 285-5019 **OR** (305) 285-2606
Miami Beach Community Health Ctr (Alton Rd.)	(305) 538-8835, Ext. 1128	(305) 795-2156
Miami Beach Community Health Ct. (Bev. Press)	(305) 538-8835, Ext. 2242, 265, and 266	(305) 867-4312
PHT/South Florida AIDS Network	(305) 585-5890	(305) 585-0088

FOR RYAN WHITE PROGRAM USE ONLY

Date: __________________________ **Notified:** ____

Approved: ______________________ **Start Date:** ____________ **Expiration Date:** _____________

Denied: _________________________ **Reason:** ____

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 3/1/09