

Proferrin<sup>®</sup> (heme iron poly)  
 Prior Authorization Form



**Complete Patient and Physician information (PLEASE PRINT)**

STEP 1	Member Name :	Physician Name:
	Address:	Address:
	Member ID:	Phone #:
	Member DOB:	Fax #:
		Tax ID or NPI #:

**If Applicable:** Pharmacy Name: \_\_\_\_\_  
 Pharmacy Phone: \_\_\_\_\_

**Complete the Clinical Assessment:**

STEP 2	Diagnosis	<input type="checkbox"/> End Stage Renal Disease (ESRD) on hemodialysis	<input type="checkbox"/> Other (please state):
	Clinical Consideration	<input type="checkbox"/> Patient must be receiving erythropoetin therapy.	<input type="checkbox"/> Other (please state):
	Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required):  Please attach a copy of the prescription or provide ALL of the information below: Proferrin <sup>®</sup> (heme iron poly) Strength _____ Sig _____ Qty _____ Refills _____  Please attach all relevant medical records and test results. <b>Incomplete forms will not be processed.</b>	

STEP 3 **I certify that the above is correct and accurate to the best of my knowledge (please sign and date).**  
 \_\_\_\_\_  
 Prescriber Signature Date

STEP 4 **Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:  
 970-248-5034**

Name of Person filling out form: \_\_\_\_\_

Pharmacy Technician initials \_\_\_\_\_ Date Initiated \_\_\_\_\_

**Confidentiality Notice:**

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