Proferrin® (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: ____________________

STEP 2

Complete the Clinical Assessment:

Diagnosis	☐ End Stage Renal Disease (ESRD) on hemodialysis	☐ Other (please state): ____________
Clinical Consideration	☐ Patient must be receiving erythropoetin therapy.	☐ Other (please state): ____________ ____________
	Diagnosis: ICD-9/10 Code #/ Description / J Code (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Proferrin® (heme iron poly) Strength ____________ Sig ____________ Qty ____________ Refills ____________	
	Please attach all relevant medical records and test results **We will not process incomplete forms.** **If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.**	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge and that the form is complete. (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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