TRICARE Prior Authorization Request Form for
epoetin alfa **(Epogen, Procrit)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete clinical assessment:**

1. Does the provider acknowledge that epoetin alfa-epbx (Retacrit) is the preferred epoetin alfa for TRICARE and is available without a prior authorization?	☐ Yes proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Has the patient experienced an inadequate response to Retacrit?	☐ Yes **Sign and date below**	☐ No proceed to question **3**
3. Has the patient had an adverse reaction to Retacrit that is not expected to occur with Procrit or Epogen?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[5 April 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: