MC-Rx
Powered by ProCare Rx

**Aranesp®**

**Ticket #:** _____ **Request Date:** _____ **Request Time:** _____

# Aranesp® Prior Authorization Request Form (Page 1 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| **Member Information** (required) | | | **Provider Information** (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Anemia due to chronic kidney disease
❑ Anemia in cancer patients on chemotherapy
❑ Anemia in patients with myelodysplastic syndrome (MDS)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

**For anemia due to chronic kidney disease, answer the following:**

Has the patient been evaluated for adequate iron stores? ❑ **Yes** ❑ **No**

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within ***30 days*** of this request:

Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____

Is the patient on dialysis? ❑ **Yes** ❑ **No**

Does the rate of hemoglobin decline indicate the likelihood of requiring a red blood cell (RBC) transfusion? ❑ **Yes** ❑ **No**

Is the goal of therapy to reduce the risk of alloimmunization and/or other RBC transfusion-related risks? ❑ **Yes** ❑ **No**

**Reauthorization:**

Has the patient been evaluated for adequate iron stores? ❑ **Yes** ❑ **No**

Is there a decrease in the need for blood transfusion with Aranesp therapy? ❑ **Yes** ❑ **No**

Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? ❑ **Yes** ❑ **No**

Document the hemoglobin (Hgb) and hematocrit (Hct) levels collected from the past 3 months:

Hgb: _____ Hct: _____ Date: _____
Hgb: _____ Hct: _____ Date: _____
Hgb: _____ Hct: _____ Date: _____

# Aranesp® Prior Authorization Request Form (Page 2 of 2)

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**For anemia in cancer patients on chemotherapy, answer the following:**

Have other causes of anemia been ruled out? ❑ **Yes** ❑ **No**

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within ***the prior two weeks*** of this request:

Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____

Has the patient been evaluated for adequate iron stores? ❑ **Yes** ❑ **No**

Is the cancer a non-myeloid malignancy? ❑ **Yes** ❑ **No**

Is the patient concurrently on chemotherapy? ❑ **Yes** ❑ **No**

Will the patient be receiving concomitant chemotherapy for a minimum of 2 months? ❑ **Yes** ❑ **No**

Is the anemia caused by cancer chemotherapy? ❑ **Yes** ❑ **No**

**Reauthorization:**

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within ***the prior two weeks*** of this request:

Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____

Is there a decrease in the need for blood transfusion with Aranesp therapy? ❑ **Yes** ❑ **No**

Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? ❑ **Yes** ❑ **No**

Is the patient concurrently on chemotherapy? ❑ **Yes** ❑ **No**

Will the patient be receiving concomitant chemotherapy for a minimum of 2 months? ❑ **Yes** ❑ **No**

Is the anemia caused by cancer chemotherapy? ❑ **Yes** ❑ **No**

**For anemia in patients with myelodysplastic syndrome (MDS), answer the following:**

Has the patient been evaluated for adequate iron stores? ❑ **Yes** ❑ **No**

Is the serum erythropoietin level less than or equal to 500 mU/mL? ❑ **Yes** ❑ **No**

Does the patient have transfusion-dependent MDS? ❑ **Yes** ❑ **No**

**Reauthorization:**

Is there a decrease in the need for blood transfusion with Aranesp therapy? ❑ **Yes** ❑ **No**

Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? ❑ **Yes** ❑ **No**

Document the hemoglobin (Hgb) and hematocrit (Hct) levels collected from the past 3 months:

Hgb: _____ Hct: _____ Date: _____

Hgb: _____ Hct: _____ Date: _____

Hgb: _____ Hct: _____ Date: _____

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

**When Completed Return To:**

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

***Please note: This request may be denied unless all required information is received.***