Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

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

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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 associated with cancer
- ❑ Anemia associated with chronic renal failure
- ❑ Anemia associated with hepatitis C treated with ribavirin and interferon
- ❑ Anemia associated with HIV/AIDS and receiving zidovudine
- ❑ Anemia associated with myelodysplastic syndrome
- ❑ Anemia associated with prematurity
- ❑ Anemia associated with sickle cell anemia
- ❑ Anemia associated with surgery undergoing elective therapy
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Document the patient's most recent hemoglobin level: _____
Submission of lab/tests indicating patient's most recent hemoglobin level is required

Select if the patient has adequate iron stores to support erythropoiesis as indicated by the following:

- ❑ Patient's serum ferritin level is greater than or equal to 100 ng/mL
- ❑ Patient's most recent transferrin saturation is greater than or equal to 20%
- ❑ Documentation of ESA drug and dosage regimen prescribed
- ❑ Documentation of anticipated length of ESA therapy
- ❑ Documentation if iron therapy is present

Submission of lab test results is required

For anemia associated with cancer, also answer the following:

Does the patient have non-myeloid malignancies (i.e., solid tumors, multiple myeloma, lymphoma, lymphocytic leukemia)? ❑ **Yes** ❑ **No**
Has the patient tried and failed Procrit? ❑ **Yes** ❑ **No**
Please document the following:
Name and date of chemotherapy:_____
Initial hemoglobin/hematocrit (H/H) levels:_____

Reauthorization:

Does the patient have non-myeloid malignancies (i.e., solid tumors, multiple myeloma, lymphoma, lymphocytic leukemia)? ❑ **Yes** ❑ **No**
Please document the following:
Name and date of chemotherapy:_____
Hemoglobin/hematocrit (H/H) levels after 8 weeks:_____

Aranesp® & Epogen® Prior Authorization Request Form (Page 2 of 2)

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For anemia associated with chronic renal failure, also answer the following:

Has the patient tried and failed Procrit? ❑ **Yes** ❑ **No**

For Epogen requests, will Epogen be used during hemodialysis? ❑ **Yes** ❑ **No**

For anemia associated with hepatitis C treated with ribavirin and interferon, also answer the following:

Is the patient's hemoglobin level less than or equal to 10 g/dL? ❑ **Yes** ❑ **No**

Is the patient unresponsive to a 200 mg/day reduction of ribavirin? ❑ **Yes** ❑ **No**

Is the patient symptomatic due to one of the following conditions: Anemia, cirrhosis, HIV coinfection, or liver transplant? ❑ **Yes** ❑ **No**

For anemia associated with HIV/AIDS and receiving zidovudine, also answer the following:

Does the patient have an endogenous erythropoietin level less than 500 mU/mL? ❑ **Yes** ❑ **No**
Submission of lab results/tests is required

Is the patient receiving a dose of zidovudine of less than or equal to 4200 mg/week? ❑ **Yes** ❑ **No**

For anemia associated with myelodysplastic syndrome, also answer the following:

Does the patient have a most recent endogenous erythropoietin level less than 500 mU/mL? ❑ **Yes** ❑ **No**
Submission of lab results/tests is required

Is the requested medication being used in combination with a granulocyte colony stimulating factor (G-CSF)? ❑ **Yes** ❑ **No**

For anemia associated with prematurity, also answer the following:

Is the patient's birth weight less than 1500 grams? ❑ **Yes** ❑ **No**

Is the patient's gestational age less than 33 weeks? ❑ **Yes** ❑ **No**

Is the requested medication being used in combination with iron supplementation? ❑ **Yes** ❑ **No**

For anemia associated with surgery undergoing elective therapy, also answer the following:

Select if the patient is undergoing one of the following elective therapies:

- ❑ Noncardiac surgery
- ❑ Nonvascular surgery

Does the patient have hemoglobin (Hgb) levels greater than 10 but less than or equal to 13 g/dL? ❑ **Yes** ❑ **No**
Submission of lab results/tests is required

Medication being provided by: (Please check applicable box below)

❑ Physician's office ❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****
Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: _____ **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?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.