

Ticket #: \_\_\_\_\_ Request Date: \_\_\_\_\_ Request Time: \_\_\_\_\_

**Aranesp® Prior Authorization Request Form (Page 1 of 2)**  
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<b>Member Information</b> (required)			<b>Provider Information</b> (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:
<b>Medication Information</b> (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
<b>Clinical Information</b> (required)					
<p><b>Select the diagnosis below:</b></p> <input type="checkbox"/> Anemia due to chronic kidney disease <input type="checkbox"/> Anemia in cancer patients on chemotherapy <input type="checkbox"/> Anemia in patients with myelodysplastic syndrome (MDS) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ _____					
<p><b>For anemia due to chronic kidney disease, answer the following:</b></p> Has the patient been evaluated for adequate iron stores? <input type="checkbox"/> Yes <input type="checkbox"/> No Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within <b>30 days</b> of this request: Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____ Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the rate of hemoglobin decline indicate the likelihood of requiring a red blood cell (RBC) transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the goal of therapy to reduce the risk of alloimmunization and/or other RBC transfusion-related risks? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<p><b>Reauthorization:</b></p> Has the patient been evaluated for adequate iron stores? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there a decrease in the need for blood transfusion with Aranesp therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? <input type="checkbox"/> Yes <input type="checkbox"/> No Document the hemoglobin (Hgb) and hematocrit (Hct) levels collected from the past 3 months: Hgb: _____ Hct: _____ Date: _____ Hgb: _____ Hct: _____ Date: _____ Hgb: _____ Hct: _____ Date: _____					

Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**  
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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.***

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