Please complete ALL information below and fax your request to 1-888-671-5285

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 **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

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? ❑ **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: ________________

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 in part by cancer chemotherapy? ❑ **Yes** ❑ **No**

< continued on the next page >

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. The information in this document is for the sole use of FutureScripts. 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.**

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

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

< continued from the previous page >

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? ❑ **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 in part 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? ❑ **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?

____

____

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

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. The information in this document is for the sole use of FutureScripts. 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.**