

Pharmacy Prior Authorization Form

Last Reviewed: Sept. 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Aranesp[®] (darbepoetin alfa) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

- 25 mcg 40 mcg 60 mcg 100 mcg 150 mcg 200 mcg 300 mcg
 Single-dose vial Single-dose prefilled *SingleJect* syringes

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization for Aranesp requires:

- Diagnosis of anemia associated with chemotherapy for non-myeloid malignancies or chronic renal failure
- Hemoglobin and hematocrit levels
 - Chemotherapy: hemoglobin level of < 10 g/dL or hematocrit level < 30%
 - Chronic renal failure: hemoglobin level 8-13 g/dL or hematocrit level > 24 to ≤ 39%
- Transferrin saturation at least 20% and serum ferritin at least 100 ng/ml
- Patient cannot have any of the following conditions/contraindications
 - Prophylaxis use to reduce tumor hypoxia
 - Uncontrolled hypertension
 - Erythyroid Cancer
 - Radiotherapy alone
 - Hematocrit level ≤ 24%
 - Chronic Myelogenous Leukemia
 - Acute Myelogenous Leukemia
 - Anemia due to folate deficiency, iron deficiency, B12 deficiency, hemolysis, bleeding or bone marrow fibrosis
 - Amemia of cancer not related to cancer treatment
 - Prophylactic use to prevent chemotherapy-induced amenia
 - Erythropoietin-type resistance due to neutralizing antibodies

Continuation of Aranesp requires:

- Chemotherapy: hemoglobin level remains < 10 g/dL or hematocrit level remains < 30%
 - Maintenance of ESA therapy is recommended at the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is ≥ 1g/dL or the rise in hematocrit ≥ 3%
 - For patients whose hemoglobin rises <1 g/dl (hematocrit rise <3%) compared to pretreatment baseline over 4 weeks of treatment and whose hemoglobin level remains

<10 g/dL after the 4 weeks of treatment or the hematocrit is <30%, the recommended FDA label starting dose may be increased once by 25%

- Continued administration of the drug is not reasonable and necessary if there is a rapid rise in hemoglobin > 1 g/dl (hematocrit > 3%) over 2 weeks of treatment unless the hemoglobin remains below or subsequently falls to < 10 g/dL (or the hematocrit is < 30%). Continuation and reinstatement of ESA therapy must include a dose reduction of 25% from the previously administered dose
- Continued use of the drug is not reasonable and necessary if the hemoglobin rises <1 g/dl (hematocrit rise <3 %) compared to pretreatment baseline by 8 weeks of treatment
- Chronic renal failure: hemoglobin level remains 8-13 g/dL or hematocrit level remains > 24 to ≤ 39%

Diagnosis:

- Non-Myeloid Malignancy
- Chronic Renal Failure/ESRD
- Other: _____

Please provide rationale for use:

Hemoglobin (Hgb)

Baseline level: _____
Current level: _____

Date of lab: _____
Date of lab: _____

Hematocrit (Hct)

Baseline level: _____
Current level: _____

Date of lab: _____
Date of lab: _____

Transferrin saturation: _____

Date of lab: _____

Serum ferritin: _____

Date of lab: _____

Patient's weight: _____

Patient is currently on dialysis:

- Yes (Part B benefit for Medicare members)
- No

Patient has the following conditions or contraindications (please check all that apply):

- Prophylaxis use to reduce tumor hypoxia
- Uncontrolled hypertension
- Erythyroid Cancer
- Radiotherapy alone
- Hematocrit level ≤ 24%
- Chronic Myelogenous Leukemia
- Acute Myelogenous Leukemia
- Anemia due to folate deficiency, iron deficiency, B12 deficiency, hemolysis, bleeding or bone marrow fibrosis
- Amemia of cancer not related to cancer treatment
- Prophylactic use to prevent chemotherapy-induced amenia
- Erythropoietin-type resistance due to neutralizing antibodies

If the patient has any of the above, please provide the rationale for use:

New request or continuation of therapy:

- New
 Continuation (please complete the continuation section)

Continuation Section:

Patient has been on Aranesp therapy for _____ weeks

Rise in Hgb over the baseline level: _____

Rise in Hct over the baseline level: _____

Continuation dose:

- Requested dose is the same as previous dose
 Requested dose is 25% higher than the previous dose
 Requested dose is 25% lower than the previous dose
 Other: Please provide the change in dose and rationale: _____

***** All fields must be complete and legible for Prior Authorization Review***
Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**