

# Pharmacy

## Prior Authorization Form

Last Reviewed: Sept. 07

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)

\*This medication must be dispensed at a participating Specialty Pharmacy.

Member Name: \_\_\_\_\_ Member #: \_\_\_\_\_ - \_\_\_\_\_  
 DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Provider Phone: \_\_\_\_\_  
 Provider Name: \_\_\_\_\_ Provider Fax: \_\_\_\_\_  
 Provider Office Contact Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Dose: (Please choose one)**
 25mcg  40mcg  60mcg  100 mcg  150mcg  200mcg  300mcg

**FDA approved indication:**

For the treatment of:

1. Anemia associated with chronic renal failure, including patients on dialysis and patients not on dialysis.
2. Anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitantly administered chemotherapy.

**Priority Health precertification requirements:**

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- Diagnosis of Anemia associated with chronic renal failure, including patients on dialysis and patients not on dialysis.
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- Patient is on dialysis
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- Patient is NOT on dialysis
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- Diagnosis of Anemia as the result of concomitantly administered chemotherapy for non-myeloid malignancies.

**Laboratory Requirements (please fill in blanks):**

	Current	Previous
Hemoglobin (g/dL)	_____ Date: _____	_____ Date: _____
Hematocrit (%)	_____ Date: _____	_____ Date: _____
Serum Ferritin (mcg/L)	_____ Date: _____	_____ Date: _____
Serum Transferrin Saturation (%)	_____ Date: _____	_____ Date: _____

Note: 1. Authorization requires Hemoglobin <10g/dL in chronic renal failure and <11g/dL in cancer AND Hematocrit <30% in chronic renal failure and <33% in cancer

2. Serum ferritin levels should be maintained > 100mg/mL and serum transferrin saturation should be maintained > 20%

**Therapy Duration:**

- The dose of Aranesp should be adjusted for each patient to achieve and maintain a target hemoglobin level not to exceed 12g/dL.

**For Internal Use Only**

Original Date of Req: \_\_\_\_\_ Non-Urgent: \_\_\_ Urgent: \_\_\_ Retro: \_\_\_ Method: Phone \_\_\_ Fax \_\_\_ Ltr \_\_\_ Coord. Initial \_\_\_  
 Approved: \_\_\_ Denied: \_\_\_ Letter Type: Denial \_\_\_ 48 hr \_\_\_ Off-Label Use \_\_\_ Verbal: Y \_\_\_ N \_\_\_ Inquiry number: \_\_\_\_\_  
 Product: HMO \_\_\_ PPO \_\_\_ ASO \_\_\_ POS \_\_\_ Caid \_\_\_ MICHild \_\_\_ Mcare \_\_\_ McarePlus \_\_\_ McareRX \_\_\_ McareValue \_\_\_  
 Formulary (11/0030/R0) \_\_\_ Non-Formulary (11/0032/R0) \_\_\_  
 Dte Addt Info Req \_\_\_\_\_ by: Phone \_\_\_ Fax \_\_\_ Dte 48/OL Ltr sent: \_\_\_\_\_ Dte 2nd 48/OL Ltr Sent (Caid only) \_\_\_\_\_  
 Date All Info Recvd \_\_\_\_\_ Date of Decision to Deny: \_\_\_\_\_ RPh Initials: \_\_\_\_\_  
 Notified: \_\_\_\_\_ of Denial on: \_\_\_\_\_ by: Ph \_\_\_ Fax \_\_\_ Provider Fax #: \_\_\_\_\_