



# Erythropoietin Injectable Medication Precertification Request Aranesp®/Epogen®/Procrit®

**Aetna Precertification Notification**  
503 Sunport Lane  
Orlando, FL 32809  
**Phone:** 1-866-503-0857  
**FAX:** 1-888-267-3277

Please indicate:  Start of treatment  Continuation of therapy

PATIENT INFORMATION			
First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:		Work Phone:	Cell Phone:
DOB:	Height:	Weight:	Allergies:
Dispensing Provider: <input type="checkbox"/> Aetna Specialty Pharmacy® or <input type="checkbox"/> Other: (Name) _____			
Phone: _____ Fax: _____ TIN: _____ PIN: _____			
If Aetna Specialty Pharmacy is dispensing, Ship to: <input type="checkbox"/> Patient's home <input type="checkbox"/> Doctor's office <input type="checkbox"/> Other: _____			

PHYSICIAN INFORMATION					
First Name:			Last Name: M.D./D.O.		
Address:			City:	State:	ZIP:
Phone:	Fax:	St. Lic. #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	
Precertification Requested By:			Phone:	Fax:	

INSURANCE INFORMATION		
Primary Insurance:		
Member ID #:	Group #:	Insured:
Secondary Insurance:		
Member ID #:	Group #:	Insured:
Medicare: <input type="checkbox"/> No <input type="checkbox"/> Yes, provide ID #: _____ Medicaid: <input type="checkbox"/> No <input type="checkbox"/> Yes, provide ID #: _____		

HISTORY & PHYSICAL FINDINGS: Please indicate which of the following apply. Specific ICD-9 codes required where indicated by "**"	
<input type="checkbox"/> 042.0 Human immunodeficiency virus (HIV)	<input type="checkbox"/> _____ Anemia of chronic illness (285.21 or 285.29) *Primary ICD-9: _____ 8-week auth.
<input type="checkbox"/> 079.53 Human immunodeficiency virus, type 2 [HIV-2]	<input type="checkbox"/> _____ Chronic kidney disease (585.1-585.9) 16-week auth.
<input type="checkbox"/> 070.41 Hepatitis C acute or unspecified with hepatic coma	<input type="checkbox"/> 585.6 ESRD with dialysis 16-week auth.
<input type="checkbox"/> 070.44 Chronic Hepatitis C with hepatic coma	<input type="checkbox"/> 776.6 Anemia of prematurity (Birth weight of _____ grams, gestational age of _____ weeks) 6-week auth.
<input type="checkbox"/> 070.51 Acute or unspecified Hepatitis C w/o mention of hepatic coma	<input type="checkbox"/> Patient scheduled to undergo high-risk surgery who is at increased risk of or intolerant to transfusions 8-week auth.
<input type="checkbox"/> 070.54 Chronic Hepatitis C w/o mention of hepatic coma	<input type="checkbox"/> _____ Malignant neoplasm (140.0-204.91) 8-week auth.
<input type="checkbox"/> 070.70 Unspecified viral Hepatitis C w/o hepatic coma	<input type="checkbox"/> _____ Myelodysplastic syndrome (238.72-238.75) 12-week auth.
<input type="checkbox"/> 070.71 Unspecified viral Hepatitis C with hepatic coma	<input type="checkbox"/> Other: _____
Is patient currently on Ribavirin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is patient on chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, date of last treatment: _____ If No, is he/she scheduled for chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, expected start date: _____	

LAB VALUES	PRESCRIPTION INFORMATION
Please note date of hemoglobin lab draw should be within 2-4 weeks prior to request.	Please select medication: <input type="checkbox"/> Aranesp <input type="checkbox"/> Epogen <input type="checkbox"/> Procrit
Hgb: _____ g/dl: (mandatory) Date drawn: _____	Please check appropriate code: <input type="checkbox"/> Q4081 (ESRD); <input type="checkbox"/> J0886 (ESRD); <input type="checkbox"/> J0882 (ESRD) <input type="checkbox"/> J0881 (non-ESRD); <input type="checkbox"/> J0885 (non-ESRD)
Ferritin: _____ or % Saturation: _____ or TIBC: _____ and Serum Fe: _____	For Hgb greater than 12 g/dl please indicate the Dosage Change: From _____ To _____ Frequency _____ Date of change _____
Date of iron stores test: _____ • Iron stores test is required for initial precert (must be drawn within past 12 months) • Is the patient receiving iron supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dose/Route/Freq: _____ Refills: _____ For ESRD with dialysis and CKD: • Doses greater than 400,000U per month may not be approved. • If Hgb is >15g/dL, dose should be held until Hgb ≤ g/dl; then restart at 50% less than previously administered dose. • If Hgb is >14 but ≤15g/dL, dose should be 25% less than previously administered dose. • If Hgb is >12 but ≤14g/dL, dose should be 10% less than previously administered dose.
When initiating therapy (Carcinoma Dx only), if Hgb is between 10-12g/dL, please document any special clinical circumstances, including co-morbidities or symptoms, to support early initiation of therapy:	
Prescriber's signature (required by law if Aetna Specialty Pharmacy is the dispensing pharmacy):	Date:

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: \_\_\_\_\_  
GR-68425 (9-09)