



**Precertification Request for Erythropoietin  
Injectable Medication (Aranesp®/Epogen®/Procrit®)  
and/or Outpatient Dialysis Treatment**

**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, date of last treatment \_\_\_\_\_ **Today's date:** \_\_\_\_\_

If ASRx dispensing, ship to:  Doctor's office  Patient  Other: \_\_\_\_\_ **Date needed:** \_\_\_\_\_  
Phone: \_\_\_\_\_

Dispensing Provider for Medication Request:  Aetna Specialty Pharmacy® (ASRx) or  Other: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ TIN: \_\_\_\_\_ PIN: \_\_\_\_\_

Requesting Outpatient Dialysis Treatment?  Yes  No If Yes, CPT Code is:  90935  90937  90999  Other \_\_\_\_\_

Is the Dispensing Provider the same facility requesting Outpatient Dialysis Treatment?  Yes  No If No, provide facility information below:  
Dialysis Facility: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ TIN: \_\_\_\_\_ PIN: \_\_\_\_\_

Precertification Requested By: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**A. PATIENT INFORMATION**

First Name: _____		Last Name: _____	
Address: _____		City: _____	State: _____ ZIP: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____	
DOB: _____	Allergies: _____	Email: _____	
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	

**B. INSURANCE INFORMATION**

Aetna Member ID #: \_\_\_\_\_ Does patient have other coverage?  Yes  No  
Group #: \_\_\_\_\_ If Yes, provide ID #: \_\_\_\_\_ Carrier Name: \_\_\_\_\_  
Insured: \_\_\_\_\_ Insured: \_\_\_\_\_

Medicare:  Yes  No If Yes, provide ID #: \_\_\_\_\_ Medicaid:  Yes  No If Yes, provide ID #: \_\_\_\_\_

**C. PRESCRIBER INFORMATION**

First Name: _____		Last Name: _____ (Circle one): M.D. D.O. N.P. P.A.	
Address: _____		City: _____	State: _____ ZIP: _____
Phone: _____	Fax: _____	St Lic #: _____	NPI #: _____ DEA #: _____ UPIN: _____
Provider Email: _____		Office Contact Name: _____ Phone: _____	

Specialty (Check one):  Nephrologist  Other: \_\_\_\_\_

**D. DIAGNOSIS INFORMATION: Please indicate primary ICD-9 code and specify where applicable (\*).**

<input type="checkbox"/> 042.0 Human immunodeficiency virus (HIV)	<input type="checkbox"/> 585.6 ESRD with dialysis 16-week auth.
<input type="checkbox"/> 079.53 Human immunodeficiency virus, type 2 [HIV-2]	<input type="checkbox"/> 776.6 Anemia of prematurity (Birth weight of _____ grams, gestational age of _____ weeks) 6-week auth.
<input type="checkbox"/> 070.41 Hepatitis C acute or unspecified with 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"/> 070.44 Chronic Hepatitis C with hepatic coma	<input type="checkbox"/> _____ *Malignant neoplasm (140.0-204.91) 8-week auth.
<input type="checkbox"/> 070.51 Acute or unspecified Hepatitis C w/o mention of hepatic coma	<input type="checkbox"/> _____ *Myelodysplastic syndrome (238.72-238.75) 12-week auth.
<input type="checkbox"/> 070.54 Chronic Hepatitis C w/o mention of hepatic coma	<input type="checkbox"/> Other: _____
<input type="checkbox"/> 070.70 Unspecified viral Hepatitis C w/o hepatic coma	
<input type="checkbox"/> 070.71 Unspecified viral Hepatitis C with hepatic coma	
<input type="checkbox"/> _____ Anemia of chronic illness (285.21 or 285.29) 8-week auth.	
<input type="checkbox"/> _____ *Primary ICD-9: _____ 8-week auth.	
<input type="checkbox"/> _____ *Chronic kidney disease (585.1-585.9) 16-week auth.	

**E. CLINICAL INFORMATION & LAB VALUES: All clinical questions must be completed for precertification request.**

<p>Please note date of hemoglobin (Hgb) lab draw should be within 2-4 weeks prior to request. Hgb: _____ g/dL: (mandatory) Date drawn: _____ Ferritin: _____ or % Saturation: _____ or TIBC: _____ and Serum Fe: _____</p> <p>Date of iron stores test: _____</p> <ul style="list-style-type: none"> <li>Iron stores test is required for initial precertification (must be drawn within past 12 months).</li> <li>Is the patient receiving iron supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <p>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: _____</p>	<p>For diagnosis CKD or ESRD target Hgb should be no greater than 11 g/dL, for over 11 g/dL please indicate the Dosage Change: From _____ To _____ Frequency _____ Date of Change _____</p> <p>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)</p> <p>For ESRD with dialysis and CKD: • Doses greater than 400,000U per month may not be approved. • If Hgb is &gt;15g/dL, dose should be held until Hgb ≤ 11g/dL; then restart at 50% less than previously administered dose. • If Hgb is &gt;14 but ≤15g/dL, dose should be 25% less than previously administered dose. • If Hgb is &gt;11 but ≤14g/dL, dose should be 10% less than previously administered dose.</p> <p>For 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: _____</p>
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**F. PRESCRIPTION: To be completed for precertification request. Prescriptions will be forwarded to Aetna Specialty Pharmacy unless otherwise noted.**

Please select medication:  
 Aranesp  Epogen  Procrit Dose/Route/Freq: \_\_\_\_\_ Refills: \_\_\_\_\_

\*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.  
\*If the prescriber is providing the drug, the provider must verify benefits.

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Required by law if this Precertification Request is also used as an Aetna Specialty Pharmacy prescription order.)

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: \_\_\_\_\_