aetna®

MEDICARE FORM

Erythropoiesis Stimulating Agents Injectable Medication Precertification Request

Page 1 of 3

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
FAX: 1-844-268-7263
PHONE: 1-866-503-0857

For other lines of business:
Please use other form

Note: Procrit and Epogen are non-preferred. The preferred products are Aranesp and Retacrit.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

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

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*Check One:* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ *Outpatient Dialysis Center* ☐ Physician's Office
☐ Retail Pharmacy ☐ Specialty Pharmacy
☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Aranesp (darbepoetin alfa)** ☐ **Epogen (epoetin alfa)** ☐ **Mircera (methoxy polyethylene glycol/epoetin beta)**
☐ **Procrit (epoetin alfa)** ☐ **Retacrit (epoetin alfa-epbx)**

Dose/Frequency: _____ **HCPCS Code:** _____
(Failure to provide dose & frequency may delay request)

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests: **(Clinical documentation required for all requests)**
☐ Yes ☐ No Will Aranesp (darbepoetin alfa), Procrit (epoetin alfa), Epogen (epoetin alfa), Mircera (methoxy polyethylene glycol/epoetin beta), or Retacrit (epoetin alfa-epbx) be used concomitantly?
☐ Yes ☐ No Is the patient currently taking iron supplements?
→ Hemoglobin (Hgb) result? _____mg/dL Date of test ____/____/____

For Initial Requests:
Note: Procrit and Epogen are non-preferred. The preferred products are Aranesp and Retacrit. Preferred products may vary based on indication.
☐ Yes ☐ No Has the patient had prior therapy with the requested product within the last 365 days?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)
☐ Aranesp (darbepoetin alfa) ☐ Retacrit (epoetin alfa-epbx)
Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)
☐ Aranesp (darbepoetin alfa) ☐ Retacrit (epoetin alfa-epbx)

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Is this request for Epogen (epoetin alfa) or Procrit (epoetin alfa)?
- ☐ Yes ☐ No Was treatment with Aranesp (darbepoetin alfa) or Retacrit (epoetin alfa-epbx) ineffective?
  - → ☐ Yes ☐ No Was treatment with Aranesp (darbepoetin alfa) or Retacrit (epoetin alfa-epbx) not tolerated, or contraindicated?
  - → Please select: ☐ not tolerated ☐ contraindicated

Please indicate the length of time on therapy: ____/____/____ - ____/____/____

☐ Yes ☐ No Does the patient experience shortness of breath, weakness, fatigue, or lightheadedness from anemia?
→ Please indicate which of the following symptoms the patient experiences: ☐ shortness of breath ☐ weakness ☐ fatigue ☐ lightheadedness

☐ Yes ☐ No Are any of the above symptoms affecting the patient's ability to perform activities of daily living?

☐ Yes ☐ No Does the patient exhibit angina, syncope, or tachycardia from anemia?
→ Please indicate which of the following symptoms of anemia the patient exhibits: ☐ angina ☐ syncope ☐ tachycardia

Which of the following laboratory test(s) has the patient had within the past 12 months?
Check all that apply and supply date and results:
- ☐ Iron Stores from Bone Marrow Iron - Date of test ____/____/____ Please indicate the result: ____ng/mL
- ☐ Serum Ferritin Levels - Date of test ____/____/____ Please indicate the result: ____ng/mL
- ☐ Serum Transferrin Saturation (TSAT) - Date of test ____/____/____ Please indicate the result: ____%

Please choose from one of the indications below:

☐ **Anemia of Prematurity:**
Please indicate the patient's birth weight in grams: ____
Please indicate the patient's gestational age in weeks: ____

☐ **Antineoplastic / Myelosuppressive Chemotherapy Induced Anemia (solid tumors, multiple myeloma, lymphoma, lymphocytic leukemia):**
- ☐ Yes ☐ No Is the intent of the treatment to decrease the need for transfusions in persons who will receive chemotherapy?
- ☐ Yes ☐ No Is the patient actively receiving chemotherapy?
  - → Date of most recent chemotherapy treatment ____/____/____
- ☐ Yes ☐ No Is the intent of the treatment to be curative?
- ☐ Yes ☐ No Is the planned chemotherapy treatment regimen to continue for a minimum of 2 months?

Continuation of treatment:
- ☐ Yes ☐ No Has there been a decrease in the need for transfusions in patients who are receiving chemotherapy?

☐ **Chronic Kidney Disease (CKD / ESRD) Induced Anemia:**
- ☐ Yes ☐ No Is the patient currently receiving dialysis?
  - → Please indicate the patient's creatinine clearance: ____mL/min Date of test ____/____/____
  - Please indicate the patient's glomerular filtration: ____mL/min/1.73m^2 Date of test ____/____/____
  - ☐ Yes ☐ No ☐ N/A Based on the decline rate of Hgb levels is there a likelihood of red blood cell transfusion?
  - ☐ Yes ☐ No Will this request be used to reduce the risk of alloimmunization and/or other RBC transfusion-related risks?
- → ☐ Yes ☐ No Is this a continuation request for a member currently on dialysis?
  - → *Check all that apply to the patient:* ☐ acute myocardial infarction (AMI) ☐ orthostatic hypotension ☐ angina ☐ living at an elevation of greater than 6000ft ☐ anemia with Hgb less than 11g/dL has significantly interfered with activities of daily living

☐ **Hepatitis C with Chemotherapy Induced Anemia:**
- ☐ Yes ☐ No Is the patient receiving interferon or pegylated interferon plus ribavirin?
- ☐ Yes ☐ No Is the patient's Hgb less than10 g/dL despite a reduction in the dose of ribavirin?

☐ **Human Immunodeficiency Virus (HIV) Disease Induced Anemia:**
Endogenous EPO level: ____mIU/mL Date of test ____/____/____
- ☐ Yes ☐ No Is the patient currently receiving zidovudine?
- ☐ Yes ☐ No Is the current zidovudine dose less than or equal to 4200 mg/week?

☐ **Myelodysplastic Syndrome Induced Anemia:**
- ☐ Endogenous serum erythropoietin (EPO) levels are less than or equal to 500 IU/L.
  - → Endogenous EPO level: ____mIU/mL Date of test ____/____/____
- ☐ Yes ☐ No Does the bone marrow have less than 15% blasts?
- ☐ Yes ☐ No Has the patient required a blood transfusion of 2 or fewer units of blood per month?

For Continuation of Therapy:
- ☐ Yes ☐ No Have the transfusion requirements been reduced by less than 50% after 6 months of therapy?

☐ **Myelofibrosis-associated Anemia:**
Endogenous EPO level: ____mIU/mL Date of test ____/____/____
- ☐ Yes ☐ No Is the member transfusion dependent?

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☐ **Miscellaneous Induced Anemias:**

Check all that apply and supply requested information:

☐ The underlying chronic disease has been identified. → Please identify the underlying chronic disease: _____

☐ The patient cannot or will not receive whole blood or components as replacement for traumatic/surgical blood loss.

☐ The patient is scheduled to undergo high-risk surgery. → Is there an increased risk of or intolerance to blood transfusions? ☐ Yes ☐ No

→ Date of surgery ____/____/____ Type of surgery: _____

Continuation of Treatment:

☐ Yes ☐ No Has the patient's hemoglobin (Hgb) risen by at least 1 g/dL while on erythropoietin stimulating treatment?

→ ***If no**, please supply rationale for continuation of treatment request:* _____

→ ***If yes**, please* indicate the pre-treatment hemoglobin level: ____g/dL Date obtained: ____/____/____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.