



Epogen®-Procrit®-Retacrit™ (epoetin-alfa) Medication Precertification Request

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(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

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

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Nephrologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for Epogen Procrit Retacrit (epoetin alfa) Dose: _____ Frequency: _____

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 the requested drug be used concomitantly with other erythropoiesis stimulating agents (ESAs)?
 Yes No Has the patient received erythropoiesis stimulating agent (ESA) therapy in the previous month (within 30 days of request)?

For ALL Initiation Requests (Clinical documentation required for all requests):
 Yes No Has the patient been assessed for iron deficiency anemia?
Please indicate the patient's most recent serum transferrin saturation (TSAT) level and date of test: _____ % Date of test: ____ / ____ / ____
 Yes No Is the patient receiving iron therapy?
 Yes No Is this request for Epogen or Procrit?
 Yes No Does the patient have a contraindication, intolerance or ineffective response to Retacrit?

Anemia in chronic kidney disease (CKD)
Please indicate the patient's pretreatment hemoglobin (Hgb) level (exclude values due to a recent transfusion): _____ Date of test: ____ / ____ / ____
 Yes No Does the patient have a contraindication, intolerance or ineffective response to Aranesp?

Anemia in myelodysplastic syndrome (MDS)
Please indicate the patient's pretreatment hemoglobin (Hgb) level (exclude values due to a recent transfusion): _____ Date of test: ____ / ____ / ____
Please indicate the patient's pretreatment serum erythropoietin level: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Anemia in CHF

Please indicate the patient's pretreatment hemoglobin (Hgb) level (exclude values due to a recent transfusion): _____ Date of test: ____/____/____

Anemia in rheumatoid arthritis

Please indicate the patient's pretreatment hemoglobin (Hgb) level (exclude values due to a recent transfusion): _____ Date of test: ____/____/____

Anemia due to hepatitis C treatment

Yes No Is the patient currently receiving treatment with ribavirin in combination with either interferon alfa or peginterferon alfa?

Please indicate the patient's pretreatment hemoglobin (Hgb) level (exclude values due to a recent transfusion): _____ Date of test: ____/____/____

Anemia due to zidovudine treatment in a patient with HIV infection

Yes No Is the patient currently receiving treatment with a zidovudine-containing medication?

Please indicate the patient's pretreatment serum erythropoietin level: _____

Please indicate the patient's pretreatment hemoglobin (Hgb) level (exclude values due to a recent transfusion): _____ Date of test: ____/____/____

Anemia in patients whose religious beliefs forbid blood transfusions

Please indicate the patient's pretreatment hemoglobin (Hgb) level (exclude values due to a recent transfusion): _____ Date of test: ____/____/____

Anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis

Please indicate the patient's pretreatment hemoglobin (Hgb) level (exclude values due to a recent transfusion): _____ Date of test: ____/____/____

Please indicate the patient's pretreatment serum erythropoietin level: _____

Anemia with malignancy

Presurgical use to reduce allogeneic blood transfusions

Yes No Is the patient scheduled to have an elective, noncardiac, nonvascular surgery?

Please indicate the patient's pretreatment hemoglobin (Hgb) level (exclude values due to a recent transfusion): _____ Date of test: ____/____/____

For Continuation Requests (clinical documentation required for all requests):

Yes No Has the patient completed at least 12 weeks of erythropoiesis stimulating agent (ESA) therapy?

→ Please indicate the number of weeks completed: _____

→ Yes No Has the patient been assessed for iron deficiency anemia?

Please indicate the patient's most recent serum transferrin saturation (TSAT) level and date of test: _____%

Date of test: ____/____/____

Yes No At any time since the patient started ESA therapy, has the patient's Hgb increased by 1 g/dL or more?

Please indicate the patient's current hemoglobin (Hgb) level (exclude values due to a recent transfusion): _____

Date of test: ____/____/____

Anemia due to hepatitis C treatment only:

Yes No Is the patient currently receiving treatment with ribavirin in combination with either interferon alfa or peginterferon alfa?

Anemia due to zidovudine treatment in a patient with HIV infection only:

Yes No Is the patient currently receiving treatment with a zidovudine-containing medication?

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.