



MEDICARE FORM

Erythropoiesis Stimulating Agents Injectable Medication Precertification Request

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(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, Mircera 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, Height, Allergies

B. INSURANCE INFORMATION: Aetna Member ID #, Group #, Insured, Does patient have other coverage?, 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, Dispensing Provider/Pharmacy, Self-administered, Physician's Office, Home, Outpatient Infusion Center, Home Infusion Center, Administration code(s) (CPT), Outpatient Dialysis Center, Retail Pharmacy, Mail Order, Other, Name, Address, Phone, Fax, TIN, PIN

E. PRODUCT INFORMATION: Request is for: Aranesp, Epogen, Mircera, Procrit, Retacrit, Dose/Frequency, HCPCS Code

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: Will Aranesp, Procrit, Epogen, Mircera, or Retacrit be used concomitantly? Is the patient currently taking iron supplements? Hemoglobin (Hgb) result? For Initial Requests: Note: Procrit and Epogen are non-preferred. Preferred products are Aranesp, Mircera and Retacrit. Preferred products may vary based on indication. Has the patient had prior therapy with the requested product within the last 365 days? Has the patient had a trial, intolerance, or contraindication to any of the following? 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?

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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.

Is this request for Epogen (epoetin alfa) or Procrit (epoetin alfa)? Was treatment with Aranesp (darbepoetin alfa), Mircera (methoxy polyethylene glycol-epoetin beta), or Retacrit (epoetin alfa-epbx) ineffective? Was treatment with Aranesp (darbepoetin alfa), Mircera (methoxy polyethylene glycol-epoetin beta), or Retacrit (epoetin alfa-epbx) not tolerated, or is contraindicated?

Does the patient experience shortness of breath, weakness, fatigue, or lightheadedness from anemia? Does the patient exhibit angina, syncope, or tachycardia from anemia?

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 Serum Ferritin Levels - Date of test Serum Transferrin Saturation (TSAT) - Date of test

Please choose from one of the indications below: Anemia of Prematurity: Antineoplastic / Myelosuppressive Chemotherapy Induced Anemia (solid tumors, multiple myeloma, lymphoma, lymphocytic leukemia): Continuation of treatment:

Chronic Kidney Disease (CKD / ESRD) Induced Anemia: Is the patient currently receiving dialysis? Please indicate the patient's creatinine clearance: Please indicate the patient's glomerular filtration: Based on the decline rate of Hgb levels is there a likelihood of red blood cell transfusion? Will this request be used to reduce the risk of alloimmunization and/or other RBC transfusion-related risks? Is this a continuation request for a member currently on dialysis?

Hepatitis C with Chemotherapy Induced Anemia: Is the patient receiving interferon or pegylated interferon plus ribavirin? Is the patient's Hgb less than 10 g/dL despite a reduction in the dose of ribavirin?

Human Immunodeficiency Virus (HIV) Disease Induced Anemia: Endogenous EPO level: Date of test Is the patient currently receiving zidovudine? 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: Date of test Does the bone marrow have less than 15% blasts? Has the patient required a blood transfusion of 2 or fewer units of blood per month?

For Continuation of Therapy: Have the transfusion requirements been reduced by less than 50% after 6 months of therapy?

Myelofibrosis-associated Anemia: Endogenous EPO level: Date of test Is the member transfusion dependent?

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

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.