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2020 Aranesp® (darbepoetin alfa) Prior Authorization Request

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(You must complete all 3 pages.)

Fax completed form to: 1-800-408-2386 **For urgent requests, please call: 1-800-414-2386**

Coverage Criteria:

- Medication is covered on plan if determined not to be covered under Medicare Part A or Medicare Part B AND when being prescribed for anemia due to chronic kidney disease in patients not on dialysis, anemia due to myelosuppressive anticancer chemotherapy in patients with non-myeloid malignancies in which chemotherapy is not being given with a curative intent, anemia due to myelodysplastic syndromes, anemia due to primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis, and anemia in cancer patients who are undergoing palliative treatment
  AND
- **For ALL REQUESTS**: patients must have a PRE-TREATMENT (no erythropoietin treatment in previous month) hemoglobin (Hgb) of less than 10 g/dL **AND** must have tried and failed or have an intolerance or contraindication to Procrit (erythropoietin injection).
  OR
- **For patients with primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia:**
  - Patient must have symptomatic anemia
    AND
  - For **INITIAL therapy,** PRE-TREATMENT (no erythropoietin treatment in previous month) serum erythropoietin levels must be less than 500 mU/ml
- **For CONTINUATION OF THERAPY for ALL patients:**
  - There must be an increase in hemoglobin (Hgb) of at least 1 g/dL after at least 12 weeks of therapy in patients not recently transfused
    AND
  - **For anemia due to myelosuppressive cancer chemotherapy:** Current hemoglobin (Hgb) must be less than 11 g/dL
    OR
  - **For all other uses:** Current hemoglobin (Hgb) must be less than or equal to 12 g/dL

Authorization duration: 16 weeks

Patient information		**Prescriber information**	
Patient name		Today's date	Physician specialty
Patient insurance ID number		Physician name	NPI/DEA number
Patient address, city, state, ZIP		Physician address, city, state, ZIP	
Patient home telephone number		M.D. office telephone number	
Gender ☐ Male ☐ Female	Patient date of birth	M.D. office fax number	

Diagnosis and medical information

Medication requested
☐ Aranesp single dose pre-filled syringe ☐ Aranesp single dose vial

Diagnosis
☐ Anemia due to chronic kidney disease (CKD)
☐ Anemia due to end stage renal disease (ESRD) with DIALYSIS
☐ Anemia due to myelosuppressive anticancer chemotherapy in patients with non-myeloid malignancies
☐ Anemia due to myelodysplastic syndromes (MDS)
☐ Anemia in primary myelofibrosis
☐ Anemia in post-polycythemia vera myelofibrosis
☐ Anemia in post-essential thrombocythemia myelofibrosis
☐ Cancer patients who are undergoing palliative treatment
☐ Other diagnosis/(ICD10) : _____

Strength and route of administration	Quantity	Day supply	Expected length of therapy

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Please check all boxes that apply:

☐ New start ☐ Restart ☐ Renewal

1. **Where is medication being administered?**
   - ☐ Patient's home (self-administered)
   - ☐ Ambulatory infusion center (infusion center supplies drug)
   - ☐ Ambulatory infusion center (pharmacy supplies drug)
   - ☐ Office administered (office supplies drug) / J CODE: _____
   - ☐ Office administered (pharmacy supplies drug)
   - ☐ Dialysis Center administered (dialysis center supplies drug)
   - ☐ Other: _____

2. ☐ **Patient is stable on current drug(s) and/or current quantity, and therapy change would likely result in adverse clinical outcome.**

3. ☐ **All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.**

4. ☐ Yes ☐ No **Is the patient currently on dialysis or will the patient be starting dialysis soon? If yes, please answer the following:**
   - ☐ Yes ☐ No Is the Aranesp to be used for a dialysis-related condition?

5. ☐ Yes ☐ No **Has the patient tried and failed or does the patient have a contraindication or intolerance to Procrit (erythropoietin injection)?**

6. ☐ Yes ☐ No **For ALL REQUESTS, was the patient's PRE-TREATMENT (no erythropoietin treatment in previous month) hemoglobin (Hgb) level less than 10 g/dL?**
   Hgb level: _____ g/dL; Date: _____

7. **For a diagnosis of primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis:**
   - ☐ Yes ☐ No **Does the patient have symptomatic anemia?**
   - ☐ Yes ☐ No **Is/was the PRE-TREATMENT serum erythropoietin level LESS than 500 mU/mL?**
     EPO level: _____ mU/mL; Date: _____

8. ☐ Yes ☐ No Is the patient receiving chemotherapy with curative intent or does the patient have myeloid cancer (such as acute myeloid leukemia [AML] or chronic myeloid leukemia [CML])?

9. For RENEWALS, please provide most current hemoglobin (Hgb) level: _____ g/dL and complete this section.
   - ☐ Yes ☐ No Has the patient had a recent blood transfusion?
   - ☐ Yes ☐ No If no recent blood transfusion, has there been an increase in hemoglobin (Hgb) of at least 1 g/dL after at least 12 weeks of therapy?
   - ☐ Yes ☐ No For anemia due to myelosuppressive anticancer chemotherapy, does the patient have a current hemoglobin (Hgb) of less than 11 g/dL?
   - ☐ Yes ☐ No For all other diagnoses, does the patient have a current hemoglobin (Hgb) less than or equal to 12 g/dL?

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Please check all boxes that apply *(continued)*:

10. ☐ Yes ☐ No **The quantity limit for all strengths of Aranesp vial and Aranesp single use prefilled syringe is 4 vials/syringes per 28 days, EXCEPT for Aranesp 500 mcg/mL prefilled syringe, which has a quantity limit of 1 syringe per 21 days. Does the patient require a higher dosage (quantity limit exception)?**

►If **YES**, indicate quantity requested: _____ per 28 days **OR** quantity _____ per day

☐ The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.

☐ The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

11. ☐ **Other supporting information:**

*NOTE: All exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature	**Date**

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