innovation HEALTH®
AETNA | INOVA

2018 Aranesp® (darbepoetin alfa) Prior Authorization Request

Page 1 of 3
(You must complete all 3 pages.)

Fax completed form to: 1-800-639-9158 **For urgent requests, please call: 1-800-551-2694**

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	Diagnosis
☐ Aranesp	☐ 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 ☐ Other diagnosis/(ICD10): _____

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

Please check all boxes that apply:

☐ New start ☐ Restart ☐ Renewal

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

2. ☐ **Has the member tried and failed Procrit® (erythropoietin injection) or does the member have a contraindication or intolerance to Procrit?**
   ☐ **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.**

3. ☐ Yes ☐ No **Is the patient on dialysis? If yes, please answer the following:**
   ☐ Yes ☐ No Does the prescriber (i.e. nephrologist, nurse practitioner, or physician assistant) receive a monthly capitation payment to manage ESRD patients' care?
   ☐ Yes ☐ No Is the Aranesp to be used for an ESRD-related condition?

(continued on page 2)

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

4. **For NEW STARTS, please complete this section.**

☐ Yes ☐ No **Does the patient meet one of the following criteria?**

- ► Adequate iron stores have been demonstrated by means of bone marrow iron or serum ferritin levels or serum iron saturation studies within the prior 12 months, or
- ► Patient has iron deficiency, but erythropoietin analog therapy will be initiated simultaneously with iron replacement

☐ Yes ☐ No **Is Aranesp requested for the treatment of anemia due to chronic kidney disease in a patient NOT on dialysis and does the patient have a hemoglobin (Hgb) level that is approaching or has fallen below 10 g/dl OR a hematocrit of 30% or less?**

☐ Yes ☐ No **Is Aranesp requested for the treatment of anemia due to chronic kidney disease in a PEDIATRIC patient and does the patient have a hemoglobin (Hgb) level that is approaching or has fallen below 12 g/dl OR a hematocrit of 30% or less?**

☐ Yes ☐ No **Is Aranesp requested for the treatment of anemia due to the start of myelosuppressive anticancer chemotherapy and the patient will have an anticipated hemoglobin (Hgb) drop associated with the therapy?**

Please complete this section below only if your patient does not meet the standard requirements listed above.

Please explain why your patient should be considered for exception although not meeting the plan's suggested PA criteria. Statement should include specifically which requirement is not met and why patient should be exempt from meeting this requirement. (Please note any information that is incomplete or illegible will delay the review process.)

5. **For RENEWALS, please complete this section.**

☐ Yes ☐ No **Did the patient have an Hgb rise of LESS THAN 1 g/dl (or hematocrit rise LESS THAN 3%) compared to pretreatment baseline by 12 weeks of treatment and an Hgb level that remained LESS THAN 10 g/dl (or hematocrit LESS THAN 30%)?**

☐ Yes ☐ No **Is Aranesp therapy being administered to an Hgb target of 12 g/dl for anemia due to myelosuppressive anticancer chemotherapy?**

☐ Yes ☐ No **Is Aranesp therapy being administered to an Hgb target of 10-11 g/dl for patients with chronic renal failure and end-stage renal disease?**

Please complete this section below only if your patient does not meet the standard requirements listed above.

Please explain why your patient should be considered for exception although not meeting the plan's suggested PA criteria. Statement should include specifically which requirement is not met and why patient should be exempt from meeting this requirement. (Please note any information that is incomplete or illegible will delay the review process.)

(continued on page 3)

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

6. ☐ Yes ☐ No **Aranesp is not covered for patients with Hgb at or above 10 g/dl (CKD not on dialysis-adult, cancer), 11 g/dl (CKD on dialysis) and 12 g/dl (pediatric CKD) or patients with uncontrolled hypertension, due to serious adverse effects. Does patient have Hgb at or above 10 g/dl (CKD not on dialysis-adult, cancer), 11 g/dl (CKD on dialysis), 12 g/dl (pediatric CKD) or uncontrolled hypertension?**

7. ☐ **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**