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 Ohio MMP:
FAX: 1-855-734-9389
PHONE: 1-855-364-0974

For other lines of business:
Please use other form

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

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:
Provider Email:	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: Epogen and Retacrit are non-preferred. The preferred products are Aranesp and Procrit. 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 and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Aranesp (darbepoetin alfa) ☐ Procrit (epoetin alfa)
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) ☐ Procrit (epoetin alfa)

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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)?
- ☐ Yes ☐ No Was treatment with Aranesp (darbepoetin alfa), Procrit (epoetin alfa), or Retacrit (epoetin alfa-epbx) ineffective?
  - → ☐ Yes ☐ No Was treatment with Aranesp (darbepoetin alfa), Procrit (epoetin 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.