Please Note: Medical Necessity Prior Authorization may be overrided for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION **BYPASS**

Aranesp® (darbepoetin alfa)

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's Needs

Name _____

Address _____

℞ *REFER FOR ANEMIA-ANABOLIC PROTOCOL*

MD _____

Signature _____

Name _____

Address _____

℞ Testosterone 200mg/ml

quantity #1 vial

sig:

as directed by physician

Dx: ANEMIA

ICD10: D 46.4

MD _____

Signature _____

SAMPLE

Prescriber Information

Last Name:	First Name
DEA/NPI:	Specialty:
Phone	Fax

Member Information

Last Name:	First Name
Member ID Number	DOB:

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

Aranesp, Epogen, Procrit Prior Authorization Form

You must answer ALL of the following questions		
1. Is the patient requesting the prescribed medication for one of the following indications? **(Please circle.)** • Secondary anemia • Reduction of allogenic blood transfusions in elective, non-cardiac, non-vascular surgery	Y	N
2. What is the primary cause of the secondary anemia? • Chronic kidney disease with dialysis • Chronic kidney disease without dialysis • Multiple myeloma • Myelosuppressive chemotherapy treatment within the last 6 weeks • Myelodysplastic syndrome • Hepatitis C therapy with ribavirin and interferon • Other_____		

3. Does the patient have a hematocrit less than 33 percent and/or hemoglobin less than 11 g/dL? *Please provide documentation.*	Y	N
4. Does the patient have a hematocrit level less than 30 percent and/or hemoglobin less than 10 g/dL? *Please provide documentation.*	Y	N
5. Does the patient have a hematocrit level between 30 to 39 percent and/or hemoglobin between 10 to 13 g/dL? *Please provide documentation.*	Y	N
6. Was the patient's ribavirin and interferon dose reduced after the onset of anemia?	Y	N
7. Were lab tests showing low hematocrit and/or hemoglobin levels administered within 30 days of this request?	Y	N

Please note, not all drugs/diagnoses are covered on all plans.

Comments: _____

Information given on this form is accurate as of this date.

Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at numbers found on the Cover Page.

I understand that USDoctor's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Contact Information:

Telephone: (855)251.9116
Fax: (248)593.9575

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PRIOR AUTHORIZATION FORM

MEMBER INFORMATION			
First Name		**Last Name**	
Plan			
Member ID		**Date of Birth**	

DRUG INFORMATION			
Drug Name			
Quantity		**ICD-10**	
Directions		**Duration of Therapy**	
Diagnosis			

PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.

Medication/Failure Reason:

IgE:_____

ESR:_____ **CRP:**_____ **# Joints:**_____ **%BSA:**_____

Height:_____ **Weight:**_____ **BMI:**_____

HA1C:_____ **Hemoglobin:**_____ **Hematocrit:**_____ **T-Score:**_____

Dialysis:_____ **Long Term Care Facility:**_____ **Self Injecting:**_____

Stimulation test:_____/_____ **Growth velocity:**_____ **#Chemotherapy cycles/month:**_____

Mini-Mental Status Test:_____ **Baseline Free testosterone/Total testosterone:**_____/_____

HCV RNA viral load:_____ **Viral Genotype:**_____ **ALT:**_____

PHYSICIAN INFORMATION			
Physician Signature		**Date**	
Physician Name		**NPI #**	
Phone Number		**Fax Number**	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function ☐ Urgent ☐ For Review	**Pharmacy Fax**	