04/30/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Aranesp (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Aranesp (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Aranesp Injection (darbepoetin alfa)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

   [If yes, skip to question 16.]

2. Is Aranesp therapy requested for a neonate? Y N

   [If yes, no further questions.]

3. Does the patient have adequate iron stores to support erythropoiesis (e.g., serum ferritin greater than 100ng/mL, transferrin saturation greater than 20%)? Please indicate Iron Studies obtained, results, and date Y N

drawn:

_____

[If no, no further questions.]

4. Have other causes of anemia been ruled out or treated (e.g., vitamin deficiency, metabolic or chronic inflammatory conditions, bleeding, etc)? Y N

   [If no, no further questions.]

5. Does the patient have a diagnosis of anemia due to chronic kidney disease? Y N

   [If no, skip to question 9.]

6. Does the patient have a hemoglobin greather than 10 g/dL within 2 weeks prior to initiating therapy? Please document hemoglobin and date drawn: Y N

   _____

   [If no, no further questions.]

7. Is the patient receiving dialysis treatments? Y N

   [If no, no further questions.]

8. Is the patient enrolled in Medicare Part B? Y N

   [No further questions.]

9. Is therapy requested for the treatment of anemia in a cancer patient? Y N

   [If no, skip to question 12.]

10. Is the patient currently receiving chemotherapy? Y N

    [If no, no further questions.]

11. Does the patient meet all of the following conditions for approval? Please document hemoglobin and date drawn: Y N

    _____

    Hemoglobin less than 10 g/dL within the 2 weeks prior to starting therapy \ Documentation to support anemia is due to concomitant myelosuppressive chemotherapy \ Diagnosis of non-myeloid malignancy (e.g., solid tumor) \ Upon initiation of therapy, there is documentation to support a minimum of two additional months of planned chemotherapy

    [No further questions.]

12. Does the patient have a diagnosis of anemia due to pegylated interferon and ribavirin treatment for hepatitis C? Y N

    [If no, no further questions.]

13. Does the patient have a hemoglobin level between 8.5 to 10 g/dL within the last 2 weeks? Please document hemoglobin and date drawn: Y N

    _____

    [If no, no further questions.]

14. Does the patient meet any of the following (high-risk group): Please indicate which apply to patient: Y N

    Cirrhosis \ Liver transplant \ HIV co-infection

    [If yes, no further questions.]

15. Has the patient responded to a ribavirin dosage adjustment? Please document the reduced dose and duration of dosage reduction: Y N

    _____

    [No further questions.]

16. Does the patient have a hemoglobin less than 11 g/dL within the last 2 weeks? Please document hemoglobin and date drawn: Y N

    _____

    [If no, no further questions.]

17. Does the patient have adequate iron stores to support erythropoiesis (e.g., serum ferritin greater than 100ng/mL, transferrin saturation greater than 20%)? Please indicate Iron Studies obtained, results, and date drawn: Y N

    _____

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date