Aetna Better Health®

Fax completed prior authorization request form to 855-799-2551 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/michigan/providers/medicaid/pharmacy

Hematopoietic Agents
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information			
☐ **Aranesp**	☐ **Procrit**	☐ **Retacrit**	☐ **Epogen**
☐ **Other, please specify:**			

Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes No	ICD-10 Code:	Diagnosis:
What medication(s) have been tried and failed for diagnosis? (please specify):		
Has the member had a therapeutic failure after one-month trial with one preferred medication?	☐ Yes	☐ No
Does the member have any of the following to the preferred medication(s): (check all that apply)	☐ Allergy ☐ Contraindication or drug interactions ☐ History of unacceptable side effects	

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information		
Chronic kidney disease Stage 3, Stage 4 (CRF-chronic renal failure) or Stage 5 (ESRD- End Stage Renal Disease); OR confirmed current chemotherapy or radiation (Epogen, Procrit, Aranesp, or Retacrit only):	☐ Member had hemoglobin level less than 10 g/dL before treatment with Epogen, Procrit, Aranesp, Retacrit or transfusions	☐ RENEWALS: member's current hemoglobin level is less than 12 g/dL
Hepatitis C with concurrent interferon treatment (Epogen, Procrit, or Retacrit only):	☐ Beginning hemoglobin level is less than 10 g/dL	☐ RENEWALS: member's current hemoglobin level is less than 12 g/dL
Kidney transplant member and transplanted kidney is noted as not yet functioning to anticipated potential (Epogen, Procrit, Aranesp, or Retacrit only):	☐ Member is less than 1-year post kidney transplant	☐ Member's current hemoglobin level is less than 12 g/dL

Anemic member scheduled to undergo non-cardiac, non-vascular surgery to decrease need for transfusions (Epogen, Procrit, and Retacrit only):	☐ Current hemoglobin level is less than 10 g/dL	☐ Clinical rationale why alternative approaches such as donating own blood prior or transfusion is not an option is provided below (required)
Anemia in AIDS patients; OR of myelodysplasia or myelodysplastic syndrome (Epogen, Procrit, or Retacrit only):	☐ Current hemoglobin level is less than 10 g/dL	

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 855-300-5528 to check the status of a request.