Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Aranesp (Medicaid)

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 at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Aranesp (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Aranesp (darbepoetin alfa)

Other, please specify_____

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: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

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

   [If yes, skip to question 10.]

2. Does the patient have adequate iron stores to support erythropoiesis as evidenced by one of the following: A) Serum ferritin greater than or equal to100 ng/ml and transferrin saturation (iron saturation) greater than or equal to 20%, or B) Normal serum iron, TIBC and serum ferritin, or C) Reticulocyte hemoglobin content (CHr) greater than 29 Y N

   Please document Iron Studies obtained, results, and date drawn:
   _____

[If no, then no further questions.]

3. Does the patient have uncontrolled high blood pressure? Y N

   [If yes, then no further questions.]

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

   [If no, skip to question 6.]

5. Does the patient have hemoglobin less than 10 g/dL within 2 weeks prior to initiating therapy? Y N

   Please document hemoglobin and date drawn: _____

   [If no, then no further questions.]

   [If yes, skip to question 9.]

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

   [If no, then no further questions.]

7. Is the patient currently receiving chemotherapy? Y N

   [If no, then no further questions.]

8. Does the patient meet all of the following conditions for approval: A) Hemoglobin less than 10 g/dL within the 2 weeks prior to starting therapy, B) Diagnosis of non-myeloid malignancy (e.g., solid tumor), and C) Patient will receive chemotherapy for at least 2 additional months Y N

   Please document hemoglobin and date drawn: _____

   [If no, no further questions.]

9. Has the patient experienced treatment failure or intolerable side effects with Epogen and Procrit? Y N

   [No further questions.]

10. Does the patient have hemoglobin less than 11 g/dL within the last 2 weeks? Y N

    Please document hemoglobin and date drawn: _____

    [If no, no further questions.]

11. Does the patient have adequate iron stores to support erythropoiesis (e.g., serum ferritin above 100ng/mL, transferrin saturation above 20%)? Y N

    Please document Iron Studies obtained, results, and date drawn:

    _____

    [No further questions.]

Comments:

_____

_____

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

_____

Prescriber (Or Authorized) Signature Date