



MEDICARE FORM

Erythropoiesis Stimulating Agents Injectable Medication Precertification Request

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(All fields must be completed and legible for precertification review)

Virginia (HMO D-SNP): FAX: 1-833-280-5224 PHONE: 1-855-463-0933

For other lines of business: Please use other form

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

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, Height, Allergies

B. INSURANCE INFORMATION: Aetna Member ID #, Group #, Insured, Does patient have other coverage?, Carrier Name

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, Office Contact Name, Phone

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION: Place of Administration, Dispensing Provider/Pharmacy, Self-administered, Physician's Office, Home, Outpatient Infusion Center, Home Infusion Center, Administration code(s) (CPT)

E. PRODUCT INFORMATION: Request is for (Aranesp, Epogen, Mircera, Procrit, Retacrit), Dose/Frequency, HCPCS Code

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, For Initial Requests, Note: Procrit and Epogen are non-preferred. Preferred products are Aranesp, Mircera and Retacrit.

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G. CLINICAL INFORMATION (Continued) - Required clinical information must be completed in its entirety for all precertification requests.

Is this request for Epogen (epoetin alfa) or Procrit (epoetin alfa)? Was treatment with Aranesp (darbepoetin alfa), Mircera (methoxy polyethylene glycol-epoetin beta), or Retacrit (epoetin alfa-epbx) ineffective? Was treatment with Aranesp (darbepoetin alfa), Mircera (methoxy polyethylene glycol-epoetin beta), or Retacrit (epoetin alfa-epbx) not tolerated, or is contraindicated? Please select: not tolerated or contraindicated

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. Are any of the above symptoms affecting the patient's ability to perform activities of daily living?

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, Serum Ferritin Levels, Serum Transferrin Saturation (TSAT)

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): Is the intent of the treatment to decrease the need for transfusions in persons who will receive chemotherapy? Is the patient actively receiving chemotherapy? Date of most recent chemotherapy treatment Is the intent of the treatment to be curative? Is the planned chemotherapy treatment regimen to continue for a minimum of 2 months?

Continuation of treatment: Has there been a decrease in the need for transfusions in patients who are receiving chemotherapy?

Chronic Kidney Disease (CKD / ESRD) Induced Anemia: Is the patient currently receiving dialysis? Please indicate the patient's creatinine clearance: Date of test Please indicate the patient's glomerular filtration: Date of test Based on the decline rate of Hgb levels is there a likelihood of red blood cell transfusion? Will this request be used to reduce the risk of alloimmunization and/or other RBC transfusion-related risks? 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: Is the patient receiving interferon or pegylated interferon plus ribavirin? Is the patient's Hgb less than 10 g/dL despite a reduction in the dose of ribavirin?

Human Immunodeficiency Virus (HIV) Disease Induced Anemia: Endogenous EPO level: Date of test Is the patient currently receiving zidovudine? 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: Date of test Does the bone marrow have less than 15% blasts? Has the patient required a blood transfusion of 2 or fewer units of blood per month?

For Continuation of Therapy: Have the transfusion requirements been reduced by less than 50% after 6 months of therapy?

Myelofibrosis-associated Anemia: Endogenous EPO level: Date of test Is the member transfusion dependent?

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G. CLINICAL INFORMATION (Continued) - Required clinical information must be completed in its entirety for all precertification requests.

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.