



**Aranesp**  
(darbepoetin alfa)

**Prior Authorization Form**  
**Curascript**  
**Fax (888)773-7386**

Last Name		First Name		Prescriber's Name		Specialty	
Home Phone		Work Phone		Office Phone		Office Fax	
Home Address		City	State	ZIP	Address		City State ZIP
SCAN ID number		Date of Birth		Est. Start Date		Office Contact	
<b>For Specialty Medications Only:</b> Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home				Special Instructions (i.e. Non-English Speaking Patient, etc.):			

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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<b>1. Is the diagnosis or indication for the treatment of anemia associated with chronic kidney disease? If no continue to #9</b>
<b>2. Is the patient on dialysis?</b>
<b>3. What are the patient's serum creatinine level, and creatinine clearance?</b>
<b>4. Is the patient iron deficient?</b>
<b>5. Is the patient currently being treated for iron deficiency?</b>
<b>6. What is the patient's current hemoglobin level?</b>
<b>7. Is this a diabetic patient with a symptomatic anemia?</b>
<b>8. What is the patient's target hemoglobin level?</b>
<b>9. Is the diagnosis or indication for the reduction of allogeneic blood transfusion in patients with non-myeloid malignancies receiving concomitant myelosuppressive chemotherapy?</b>
<b>10. Is the anticipated outcome of myelosuppressive chemotherapy cure?</b>
<b>11. What is the patient's current hemoglobin level?</b>
<b>12. Has the patient tried Procrit for greater than one month with an inadequate response? (Documentation in the chart notes must be provided)</b>
<b>13. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?</b>

Physician's Signature: \_\_\_\_\_ NPI/DEA #: \_\_\_\_\_ Date: \_\_\_\_\_

<u>For Internal Use Only</u>			
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	Reviewer's Initials _____	Decision Date _____
Comments _____			

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.