



Aranesp
(darbepoetin alfa)
Prior Authorization Form

Express Scripts
Phone 800-417-8164
Fax 877-837-5922

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
For Specialty Medications Only: 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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- 1. Is the diagnosis or indication for the treatment of anemia associated with chronic kidney disease? If no continue to #9**
- 2. Is the patient on dialysis?**
- 3. Does the patient have a creatinine of 2.0 or greater or the creatinine clearance by any standard method is less than 45ml/min?**
- 4. Is the patient iron deficient? If no continue to #6**
- 5. Is the patient currently being treated for iron deficiency?**
- 6. Is the patient's current (or pre-transfusion) hemoglobin level <10g/dl?**
- 7. Is this a diabetic patient with a symptomatic anemia?**
- 8. What is the patient's target hemoglobin level within the range of 10 to 12 g/dl?**
- 9. Is the diagnosis or indication for the reduction of allogeneic blood transfusion in patients with non-myeloid malignancies receiving concomitant myelosuppressive chemotherapy?
If no, continue to #11.**
- 10. Is the patient's current hemoglobin level ≥ 10g/dl? If no, continue to #14**
- 11. Is the diagnosis or indication for the treatment of anemia in low or intermediate-1 risk Myelodysplastic Syndrome (MDS) patients?**

12. Is the patient transfusion-dependent?
13. Is the patient symptomatic from anemia, documented by such impairments as moderate to severe exercise intolerance, inability to perform activities of daily living, tachycardia or shortness of breath with minimal activities?
14. Has the patient tried Procrit for greater than one month with an inadequate response? (Documentation in the chart notes must be provided)
15. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

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>.