



**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
VH 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 one of the following? <i>Must be indicated.</i></b> <input type="checkbox"/> Anemia associated with chronic kidney disease? <input type="checkbox"/> Chemotherapy induced anemia (nonmyeloid)
<b>2. Is the patient on dialysis?</b>
<b>3. What are the patient's serum creatinine level, creatinine clearance, and weight?</b>
<b>4. Is the patient iron deficient?</b>
<b>5. Is the patient not currently being treated for this deficiency?</b>
<b>6. What is the patient's target hemoglobin level?</b>
<b>7. Does the patient have a diagnosis of uncontrolled hypertension?</b>
<b>8. Has the patient tried Procrit for more than one month with an inadequate response? (Documentation in chart notes/labs must be provided).</b>
<b>9. 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>.