Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Aranesp - Mircera (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 New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Aranesp - Mircera (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Aranesp (darbepoetin alfa) Mircera (methoxy polyethylene glycol-epoetin beta)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

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

   [If no, skip to question 3.]

2. Does the member meet both of the following conditions for approval: A) hemoglobin less than 11 g/dL within the last 2 weeks, and B) member has had follow up iron studies showing adequate iron stores to support erythropoiesis (e.g., serum ferritin at least 100ng/mL, transferrin saturation at least 20 percent)? Y N

   Please document hemoglobin and results of iron studies including date drawn: _____

[No further questions.]

3. Does the member have adequate iron stores to support erythropoiesis as evidenced by one of the following: A) serum ferritin greater than or equal to 100 ng/ml and transferrin saturation (iron saturation) greater than or equal to 20 percent, or B) reticulocyte hemoglobin content (CHr) greater than 29 pg? Y N

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

   [If no, then no further questions.]

4. Does the member have uncontrolled hypertension (high blood pressure)? Y N

   [If yes, then no further questions.]

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

   [If no, skip to question 7.]

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

   Please document hemoglobin and date drawn: _____

   [If yes, skip to question 10.] [If no, then no further questions.]

7. Is therapy requested for the treatment of anemia in a cancer member? Y N

   [If no, then no further questions.]

8. Is the member currently receiving myelosuppressive chemotherapy? Y N

   [If no, then no further questions.]

9. Does the member 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 (for example, solid tumor), and C) member will receive chemotherapy for at least 2 additional months? Y N

   Please document hemoglobin and date drawn: _____

   [If no, no further questions.]

10. Has the member experienced treatment failure or intolerable side effects with all of the following: A) Epogen, B) Procrit, and C) Retacrit? Y N

Comments:

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

Prescriber (Or Authorized) Signature **Date**