OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Aranesp® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Anemia due to chronic kidney disease
❑ Anemia in cancer patients on chemotherapy
❑ Anemia in patients with myelodysplastic syndrome (MDS)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

For anemia due to chronic kidney disease, answer the following:

Has the patient been evaluated for adequate iron stores? ❑ **Yes** ❑ **No**
Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within ***30 days*** of this request:
Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____
Is the patient on dialysis? ❑ **Yes** ❑ **No**
Does the rate of hemoglobin decline indicate the likelihood of requiring a red blood cell (RBC) transfusion? ❑ **Yes** ❑ **No**
Is the goal of therapy to reduce the risk of alloimmunization and/or other RBC transfusion-related risks? ❑ **Yes** ❑ **No**

Reauthorization:

Has the patient been evaluated for adequate iron stores? ❑ **Yes** ❑ **No**
Is there a decrease in the need for blood transfusion with Aranesp therapy? ❑ **Yes** ❑ **No**
Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? ❑ **Yes** ❑ **No**
Document the hemoglobin (Hgb) and hematocrit (Hct) levels collected from the past 3 months:
Hgb: _____ Hct: _____ Date: _____
Hgb: _____ Hct: _____ Date: _____
Hgb: _____ Hct: _____ Date: _____

For anemia in cancer patients on chemotherapy, answer the following:

Have other causes of anemia been ruled out? ❑ **Yes** ❑ **No**
Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within ***the prior two weeks*** of this request:
Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____
Has the patient been evaluated for adequate iron stores? ❑ **Yes** ❑ **No**
Is the cancer a non-myeloid malignancy? ❑ **Yes** ❑ **No**
Is the patient concurrently on chemotherapy? ❑ **Yes** ❑ **No**
Will the patient be receiving concomitant chemotherapy for a minimum of 2 months? ❑ **Yes** ❑ **No**
Is the anemia caused by cancer chemotherapy? ❑ **Yes** ❑ **No**

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Aranesp® Prior Authorization Request Form (Page 2 of 2)

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Reauthorization:

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within ***the prior two weeks*** of this request:

Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____

Is there a decrease in the need for blood transfusion with Aranesp therapy? ❑ **Yes** ❑ **No**

Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? ❑ **Yes** ❑ **No**

Is the patient concurrently on chemotherapy? ❑ **Yes** ❑ **No**

Will the patient be receiving concomitant chemotherapy for a minimum of 2 months? ❑ **Yes** ❑ **No**

Is the anemia caused by cancer chemotherapy? ❑ **Yes** ❑ **No**

For anemia in patients with myelodysplastic syndrome (MDS), answer the following:

Has the patient been evaluated for adequate iron stores? ❑ **Yes** ❑ **No**

Is the serum erythropoietin level less than or equal to 500 mU/mL? ❑ **Yes** ❑ **No**

Does the patient have transfusion-dependent MDS? ❑ **Yes** ❑ **No**

Reauthorization:

Is there a decrease in the need for blood transfusion with Aranesp therapy? ❑ **Yes** ❑ **No**

Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? ❑ **Yes** ❑ **No**

Document the hemoglobin (Hgb) and hematocrit (Hct) levels collected from the past 3 months:

Hgb: _____ Hct: _____ Date: _____

Hgb: _____ Hct: _____ Date: _____

Hgb: _____ Hct: _____ Date: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.