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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Mircera<sup>®</sup> Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:	Dosage Form:	
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Anemia due to chronic kidney disease					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Medication History:</b>					
Is this request for continuation of prior Mircera therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is there history of use or unavailability of Aranesp? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is there history of use or unavailability of Procrit? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Clinical Information:</b>					
Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient been evaluated for adequate iron stores? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please provide the Hgb and Hct levels collected within <b>30 days</b> of this request:					
Hemoglobin (Hgb): _____ Date: _____ Hematocrit (Hct): _____ Date: _____					
Does the rate of hemoglobin decline indicate the likelihood of requiring a red blood cell (RBC) transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the goal of therapy to reduce the risk of alloimmunization and/or other RBC transfusion-related risks? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient on hemodialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient's hemoglobin level been stabilized by treatment with another erythropoietin stimulating agent (ESA) (e.g., Aranesp, Procrit)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient converting to Mircera from another ESA (e.g., Aranesp, Procrit)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization:</b>					
<b>If this is a reauthorization request, answer the following questions:</b>					
Has the patient been evaluated for adequate iron stores? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is there a decrease in the need for blood transfusion with Mircera therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the hemoglobin increased greater than or equal to 1g/dL from pre-treatment level? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Document the hemoglobin (Hgb) and hematocrit (Hct) levels collected from the past 3 months:					
Hgb: _____		Hct: _____		Date: _____	
Hgb: _____		Hct: _____		Date: _____	
Hgb: _____		Hct: _____		Date: _____	

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Mircera\_Comm\_2018Dec-W



**Mircera<sup>®</sup> Prior Authorization Request Form (Page 2 of 2)**  
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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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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.