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

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

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

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

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication History:

Is this request for continuation of prior Mircera therapy? ❑ **Yes** ❑ **No**

Is there history of use or unavailability of Aranesp? ❑ **Yes** ❑ **No**

Is there history of use or unavailability of Procrit? ❑ **Yes** ❑ **No**

Clinical Information:

Is the patient on dialysis? ❑ **Yes** ❑ **No**

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

Please provide the Hgb and Hct levels collected within ***30 days*** 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? ❑ **Yes** ❑ **No**

Is the goal of therapy to reduce the risk of alloimmunization and/or other RBC transfusion-related risks? ❑ **Yes** ❑ **No**

Is the patient on hemodialysis? ❑ **Yes** ❑ **No**

Has the patient's hemoglobin level been stabilized by treatment with another erythropoietin stimulating agent (ESA) (e.g., Aranesp, Procrit)? ❑ **Yes** ❑ **No**

Is the patient converting to Mircera from another ESA (e.g., Aranesp, Procrit)? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

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

Is there a decrease in the need for blood transfusion with Mircera 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: _____

Mircera® 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?

_____

_____

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.