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)			**Provider Information** (required)		
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 (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 in cancer patients on chemotherapy
❑ Anemia in chronic kidney disease (CKD)
❑ Anemia in myelodysplastic syndrome (MDS)
❑ Other diagnosis: ____________________________________ ICD-10 Code(s): ____________________________________

Clinical Information:

Is the patient on dialysis? ❑ **Yes** ❑ **No**
Does the patient have end-stage renal disease (ESRD)? ❑ **Yes** ❑ **No**
Is the dialysis provider (i.e., nephrologist, nurse practitioner, physician assistant, or dialysis center) receiving a monthly capitation payment to manage the patient's ESRD care? ❑ **Yes** ❑ **No**
Has the patient been evaluated for adequate iron stores? ❑ **Yes** ❑ **No**

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

Have all other causes of anemia been ruled out? ❑ **Yes** ❑ **No**
Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within **2 weeks** of this request:
Hgb: __________ g/dL Hct: ___________ % Date: ________________________
Is the patient's 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 the cancer chemotherapy? ❑ **Yes** ❑ **No**

Reauthorization:

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within **2 weeks** of this request:
Hgb: __________ g/dL Hct: ___________ % Date: ________________________
Has the patient had a decrease in the need for blood transfusion? ❑ **Yes** ❑ **No**
Has the patient's hemoglobin (Hgb) increased by 1 g/dL or more from pre-treatment level? ❑ **Yes** ❑ **No**
Is the patient currently on chemotherapy? ❑ **Yes** ❑ **No**
Will the patient be receiving concomitant chemotherapy for a minimum of 2 months? ❑ **Yes** ❑ **No**
Is the anemia caused by the cancer chemotherapy? ❑ **Yes** ❑ **No**

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.**

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

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For anemia in chronic kidney disease (CKD) , also answer the following:

Please provide the hemoglobin (Hgb) and hematocrit (Hct) levels collected within **30 days** of this request:

Hgb: __________ g/dL Hct: ___________ % Date: ________________________

Does the rate of hemoglobin decline indicate the likelihood of requiring a red blood cell (RBC) transfusion? ❑ **Yes** ❑ **No**

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

Reauthorization:

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

Does the patient have end-stage renal disease (ESRD)? ❑ **Yes** ❑ **No**

Document the monthly hemoglobin (Hgb) and hematocrit (Hct) levels collected over a **3 month** period:

Hgb: __________ g/dL Hct: ___________ % Date: ________________________

Hgb: __________ g/dL Hct: ___________ % Date: ________________________

Hgb: __________ g/dL Hct: ___________ % Date: ________________________

Has the patient had a decrease in the need for blood transfusion? ❑ **Yes** ❑ **No**

Has the patient's hemoglobin (Hgb) increased by 1 g/dL or more from pre-treatment level? ❑ **Yes** ❑ **No**

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

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

Does the patient have a serum erythropoietin level of 500 mU/mL or less? ❑ **Yes** ❑ **No**

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

Reauthorization:

Document the monthly hemoglobin (Hgb) and hematocrit (Hct) levels collected over a **3 month** period:

Hgb: __________ g/dL Hct: ___________ % Date: ________________________

Hgb: __________ g/dL Hct: ___________ % Date: ________________________

Hgb: __________ g/dL Hct: ___________ % Date: ________________________

Has the patient had a decrease in the need for blood transfusion? ❑ **Yes** ❑ **No**

Has the patient's hemoglobin (Hgb) increased by 1 g/dL or more from pre-treatment level? ❑ **Yes** ❑ **No**

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.

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