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

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 in chronic kidney disease (CKD)

❑ 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**

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**

Select if the patient has history of failure, contraindication, or intolerance to the following:

❑ Aranesp ❑ Epogen ❑ Procrit

Reauthorization:

Is the patient on dialysis? ❑ **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**

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.
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.