



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) | | | 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: |
| <input type="checkbox"/> Check if requesting brand | Directions for Use: | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | |

| Clinical Information (required) | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Select the diagnosis below: | |
| <input type="checkbox"/> Anemia in chronic kidney disease (CKD) | |
| <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ | |
| Clinical Information: | |
| Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Does the patient have end-stage renal disease (ESRD)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <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 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Is reducing the risk of alloimmunization and/or other RBC transfusion-related risks a goal? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Select if the patient has history of failure, contraindication, or intolerance to the following: | |
| <input type="checkbox"/> Aranesp <input type="checkbox"/> Epogen <input type="checkbox"/> Procrit | |
| Reauthorization: | |
| Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Has the patient's hemoglobin (Hgb) increased by 1 g/dL or more from pre-treatment level? <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 | |

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.

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.**

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