REALRx

PRIOR AUTHORIZATION REQUEST FORM
ARANESP®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Aranesp® (darbepoetin alfa)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	☐	☐	
2. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
3. Is the requesting provider a hematologist, oncologist, nephrologist, or in consultation with one?	☐	☐	
4. Does documentation show that the member's hemoglobin is <10 g/dL and/or that the hematocrit is <30%?	☐	☐	**Please provide documentation**
5. Does the member have one of the following indications: • Anemia of chronic renal failure, • Anemia due to myelosuppressive chemotherapy with a minimum of 8 additional weeks of planned chemotherapy, • Myelodysplasia or myelodysplastic syndrome?	☐	☐	**Please provide documentation**
6. Does the member have one of the following indications: • Request will be used as a substitute for red blood cell transfusion in patients who require immediate correction of anemia, • Uncontrolled hypertension, • Pure Red Cell Aplasia (PRCA) that begins after treatment with erythropoietin drugs?	☐	☐	

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member responded to treatment, demonstrated by an improvement in the hematocrit and hemoglobin levels or a significant decrease in transfusion requirements?	☐	☐	**Please provide documentation**
3. Is current hemoglobin < 11g/dL OR > 10 to <12 g/dL?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy: PHARM-008
Origination Date: 05/24/2018
Reviewed/Revised Date: 01/17/2024
Next Review Date: 01/17/2025
Current Effective Date: 02/01/2024