



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)  
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)  
Aranesp (Medicare Prior Authorization)**

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.  
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.  
When conditions are met, we will authorize the coverage of Aranesp (Medicare Prior Authorization).

**Drug Name (select from list of drugs shown)**

Aranesp (darbepoetin alfa)

**Patient Information**

Patient  
Name: \_\_\_\_\_  
Patient ID: \_\_\_\_\_  
Patient  
Group No.: \_\_\_\_\_  
Patient  
DOB: \_\_\_\_\_

**Prescribing Physician**

Physician  
Name: \_\_\_\_\_  
Physician  
Phone: \_\_\_\_\_  
Physician  
Fax: \_\_\_\_\_  
Physician  
Address: \_\_\_\_\_  
City, State,  
Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Please circle the appropriate answer for each applicable question.

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|----|--|---|---|
| 1. | Does the patient have a diagnosis of uncontrolled hypertension?<br>[If the answer to this question is yes, then no further questions.]   | Y | N |
| 2. | Does the patient have a diagnosis of metastatic, non-myeloid malignancies?<br>[If the answer to this question is no, then may skip to question 7.]   | Y | N |
| 3. | Is the patient currently receiving myelosuppressive chemotherapy?<br>[If the answer to this question is no, then no further questions.]  | Y | N |
| 4. | Is the patient receiving myelosuppressive chemotherapy for curative intent?<br>[If the answer to this question is yes, then no further questions.]   | Y | N |
| 5. | Will Aranesp be discontinued after a completion of a chemotherapy course?<br>[If the answer to this question is no, then no further questions.]  | Y | N |
| 6. | Does the patient have pre-treatment hemoglobin level less than 10 g/dL or 10-11 g/dL with clinical symptoms?<br>[If the answer to this question is yes, then may skip to question 12. If the answer is no, then no further questions.] | Y | N |

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|-----|--|---|---|
| 7.  | Does the patient have a diagnosis of chronic renal failure (CRF)?<br>[If the answer to this question is no, then no further questions.]  | Y | N |
| 8.  | Does the patient have pre-treatment hemoglobin level less than 12 g/dL?<br>[If the answer to this question is no, then no further questions.]  | Y | N |
| 9.  | Was the iron status (transferrin saturation) of the patient evaluated at baseline and will be monitored throughout the therapy?<br>[If the answer to this question is no, then no further questions.]  | Y | N |
| 10. | Is the transferrin saturation of the patient greater than or equal to 20%?<br>[If the answer to this question is yes, then may skip to question 12.]   | Y | N |
| 11. | Will the patient receive iron supplementation?<br>[If the answer to this question is no, then no further questions.]   | Y | N |
| 12. | Will the hemoglobin level of the patient be monitored prior to each dose, for dose changes, and at regular intervals when the dose is stabilized?<br>[If the answer to this question is no, then no further questions.]  | Y | N |
| 13. | Has the patient received Aranesp or an erythropoietin product (Procrit or Epogen) in the previous month?<br>[If the answer to this question is no, then may skip to question 21.]  | Y | N |
| 14. | Has the patient completed at least 8 weeks of Aranesp therapy?<br>[If the answer to this question is no, then may skip to question 16.]  | Y | N |
| 15. | Compared to pretreatment baseline, has the patient shown an objective clinical response (e.g., hemoglobin rise greater than or equal to 1 g/dL and/or hematocrit rise greater than or equal to 3%) to an appropriate dose/dose increase and duration of therapy?<br>[If the answer to this question is no, then no further questions.] | Y | N |
| 16. | Is the current hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 12 g/dL?<br>[If the answer to this question is no, then may skip to question 19.]   | Y | N |
| 17. | Was the previous hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 12 g/dL?<br>[If the answer to this question is yes, then no further questions.]   | Y | N |
| 18. | Will the prescriber be holding dose administration until the hemoglobin level is less than 12 g/dL?<br>[If the answer to this question is yes, then may skip to question 21. If the answer is no, then no further questions.]  | Y | N |
| 19. | Has the hemoglobin level of the patient increased more than 1.0 g/dL in any 2 week period?<br>[If the answer to this question is no, then may skip to question 21.]  | Y | N |
| 20. | Will the prescriber be reducing dose of Aranesp to avoid rapid rise in hemoglobin level?<br>[If the answer to this question is no, then no further questions.]   | Y | N |
| 21. | Will the blood pressure of the patient be monitored throughout therapy?<br>[If the answer to this question is no, then no further questions.]  | Y | N |
| 22. | Will the patient be monitored for the occurrence of cardiovascular and thrombotic events?  | Y | N |

**Comments:** \_\_\_\_\_

I affirm that the information given on this form is true and accurate as of this date.



**Arkansas  
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

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**Prescriber (Or Authorized) Signature and Date**