



Prescription Drug Coverage Determination Form

Erythropoietic

Aranesp® (darbepoetin alfa)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-647-2240.

Patient Information

Patient Name: _____ Date of Birth: _____
Subscriber ID#: _____
Address _____ City _____ State _____ Zip Code _____

Physician Information

Name: _____ Specialty: _____ Tax ID#: _____
Office Address _____ City _____ State _____ Zip Code _____
Telephone: _____ Fax: _____ Contact Person _____

Physician Signature (REQUIRED): _____ Date _____

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: _____ J-code: _____
Dose: _____ Directions: _____
Expected Duration of Therapy: _____

Prior Authorization Criteria:

- 1. Does the patient have a diagnosis of chronic renal failure including patients receiving dialysis? Yes No
- 2. Is the patient an adult with a diagnosis of non-myeloid malignancy? Yes No
- 3. Is the patient currently receiving chemotherapy for treatment of the malignancy? Yes No
- 4. Does the patient now or initially have a diagnosis of anemia? Yes No
 - If no:
 - Is the patient symptomatic? Yes No
 - Hgb _____ Hct _____
- 5. Has the iron status of the patient been evaluated (serum ferritin level and serum transferrin saturation)? Yes No
- 6. Will the iron status of the patient be evaluated during therapy? Yes No
- 7. Is the transferrin saturation of the patient $\geq 20\%$? Yes No
 - If no:
 - Will the patient receive iron supplementation/replenishment therapy, as deemed appropriate by prescriber? Yes No

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| 6. Will the hemoglobin level be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Is the patient's hemoglobin level (not a result of a recent blood transfusion) >13 g/dL? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Has the patient used Aranesp® or an erythropoietin product (Epogen or Procrit) in the previous month? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Has the hemoglobin level of the patient increased more than 1.0 g/dL in any 2 week period? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes: | | |
| ▪ Has the physician considered a reduction in the dosage or an interruption of therapy (i.e., therapy has or will be stopped and then restarted at a reduced dose)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Will the blood pressure of the patient be monitored throughout therapy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Will the patient be monitored for the occurrence of thrombotic events? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.