Precertification Request for Erythropoietin Injectable Medication (Aranesp®/Epogen®/Procrit®) and/or Outpatient Dialysis Treatment

Aetna Precertification Notification
503 Sunport Lane
Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: ☐ Start of treatment ☐ Continuation of therapy, date of last treatment _____ **Today's date:** _____
Date needed: _____

If ASRx dispensing, ship to: ☐ Doctor's office ☐ Patient ☐ Other: _____ Phone: _____
Dispensing Provider for Medication Request: ☐ Aetna Specialty Pharmacy® (ASRx) or ☐ Other: _____
Phone: _____ Fax: _____ **TIN:** _____ PIN: _____
Requesting Outpatient Dialysis Treatment? ☐ Yes ☐ No If Yes, **CPT Code is:** ☐ 90935 ☐ 90937 ☐ 90999 ☐ Other _____
Is the Dispensing Provider the same facility requesting Outpatient Dialysis Treatment? ☐ Yes ☐ No If No, provide facility information below:
Dialysis Facility: _____ Phone: _____ Fax: _____ **TIN:** _____ PIN: _____
Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #:_____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If Yes, provide ID #: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If Yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If Yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Circle one):* M.D. D.O. N.P. P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Nephrologist** ☐ **Other**: _____

D. DIAGNOSIS INFORMATION: Please indicate primary ICD-9 code and specify where applicable (*).

☐ 042.0 Human immunodeficiency virus (HIV)
☐ 079.53 Human immunodeficiency virus, type 2 [HIV-2]
☐ 070.41 Hepatitis C acute or unspecified with hepatic coma
☐ 070.44 Chronic Hepatitis C with hepatic coma
☐ 070.51 Acute or unspecified Hepatitis C w/o mention of hepatic coma
☐ 070.54 Chronic Hepatitis C w/o mention of hepatic coma
☐ 070.70 Unspecified viral Hepatitis C w/o hepatic coma
☐ 070.71 Unspecified viral Hepatitis C with hepatic coma
☐ _____ Anemia of chronic illness (285.21 or 285.29)
*Primary ICD-9: _____ *8-week auth.*
☐ _____ *Chronic kidney disease (585.1-585.9) *16-week auth.*

☐ 585.6 ESRD with dialysis *16-week auth.*
☐ 776.6 Anemia of prematurity (Birth weight of _____ grams, gestational age of _____ weeks) *6-week auth.*
☐ Patient scheduled to undergo high-risk surgery who is at increased risk of or intolerant to transfusions *8-week auth.*
☐ _____ *Malignant neoplasm (140.0-204.91) *8-week auth.*
☐ _____ *Myelodysplastic syndrome (238.72-238.75) *12-week auth.*
☐ Other: _____

E. CLINICAL INFORMATION & LAB VALUES: All clinical questions must be completed for precertification request.

Please note date of hemoglobin (Hgb) lab draw should be within 2-4 weeks prior to request.
Hgb: _____ g/dL: (mandatory)
Date drawn: _____
Ferritin: _____ or % Saturation: _____
or TIBC: _____ and Serum Fe: _____
Date of iron stores test: _____
- Iron stores test is **required for initial precertification** (must be drawn within past 12 months).
- Is the patient receiving iron supplements? ☐ Yes ☐ No

Is patient currently on Ribavirin? ☐ Yes ☐ No
Is patient on chemotherapy? ☐ Yes ☐ No
If Yes, date of last treatment: _____
If No, is he/she scheduled for chemotherapy? ☐ Yes ☐ No
If Yes, expected start date: _____

For diagnosis CKD or ESRD target Hgb should be no greater than 11 g/dL, for over 11 g/dL please indicate the Dosage Change:
From _____ To _____
Frequency _____ Date of Change _____
Please check appropriate code:
☐ Q4081 (ESRD); ☐ J0886 (ESRD); ☐ J0882 (ESRD)
☐ J0881 (non-ESRD); ☐ J0885 (non-ESRD)
For ESRD with dialysis and CKD:
- Doses greater than 400,000U per month may not be approved.
- If Hgb is >15g/dL, dose should be held until Hgb ≤ 11g/dL; then restart at 50% less than previously administered dose.
- If Hgb is >14 but ≤15g/dL, dose should be 25% less than previously administered dose.
- If Hgb is>11 but ≤14g/dl, dose should be 10% less than previously administered dose.

For Carcinoma Dx Only: If Hgb is between 10-12g/dL, please document any special clinical circumstances including co-morbidities or symptoms to support early initiation of therapy: _____

F. PRESCRIPTION: To be completed for precertification request. Prescriptions will be forwarded to Aetna Specialty Pharmacy unless otherwise noted.

Please select medication:
☐ **Aranesp** ☐ **Epogen** ☐ **Procrit** Dose/Route/Freq: _____ Refills: _____

***If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.**
***If the prescriber is providing the drug, the provider must verify benefits.**
Prescriber's Signature:_____ **Date:** ____/____/____
(Required by law if this Precertification Request is also used as an Aetna Specialty Pharmacy prescription order.)
Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: _____