

**Aranesp (epoetin alfa)**  
**Prior Authorization Request Form**

Caterpillar Prescription Drug Benefit  
Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

**URGENT**

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE  FEMALE HEIGHT (IN/CM): \_\_\_\_\_ WEIGHT (LB/KG): \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [PRIMETHERAPEUTICS.COM/NOPP](http://PRIMETHERAPEUTICS.COM/NOPP)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): \_\_\_\_\_  
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: \_\_\_\_\_

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

*Continued on next page.*

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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Reduction of allogenic blood transfusions in elective, non-cardiac, non-vascular surgery <input type="checkbox"/> Secondary anemia <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p><b>Has patient previously tried Retacrit (epoetin alfa-epbx)?</b>   <input type="checkbox"/> Yes <input type="checkbox"/> No   <i>Please provide documentation.</i></p> <p><b>For reduction of allogenic blood transfusions in elective, non-cardiac, non-vascular surgery, also answer the following:</b>  <b>Does the patient have a hematocrit level between 30 to 39 percent and/or hemoglobin between 10 to 13 g/dL?*</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>*Please provide documentation</i></p> <p><b>Were lab tests showing low hematocrit and/or hemoglobin levels administered within 30 days of this request?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>For secondary anemia, also answer the following:</b>  <b>Select the primary cause of the secondary anemia for the patient:</b>  <input type="checkbox"/> Chronic kidney disease with dialysis  <input type="checkbox"/> Chronic kidney disease without dialysis  <input type="checkbox"/> Multiple myeloma  <input type="checkbox"/> Myelosuppressive chemotherapy  <input type="checkbox"/> Myelodysplastic syndrome  <input type="checkbox"/> Hepatitis C therapy with ribavirin and interferon treatment  <input type="checkbox"/> Other _____</p> <p><b>Secondary anemia due to chronic kidney disease with dialysis or myelodysplastic syndrome, answer the following:</b>  <b>Does the patient have a hematocrit less than 33 percent and/or hemoglobin less than 11 g/dL?</b>   <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>Please provide documentation</i></p> <p><b>Were lab tests showing low hematocrit and/or hemoglobin levels administered within 30 days of this request?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Secondary anemia due to chronic kidney disease without dialysis, multiple myeloma, or myelosuppressive chemotherapy treatment within the last 6 weeks, answer the following:</b></p>		

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Does the patient have a hematocrit less than 30 percent and/or hemoglobin less than 10 g/dL?  Yes  No  
Please provide documentation

Were lab tests showing low hematocrit and/or hemoglobin levels administered within 30 days of this request?  
 Yes  No

Secondary anemia due to Hepatitis C therapy with ribavirin and interferon, answer the following:  
Was the patient's ribavirin and interferon dose reduced after the onset of anemia?  Yes  No

Does the patient have a hematocrit less than 33 percent and/or hemoglobin less than 11 g/dL?  Yes  No  
*Please provide documentation*

Were lab tests showing low hematocrit and/or hemoglobin levels administered within 30 days of this request?  
 Yes  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?

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**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640**  
**MAIL REQUESTS TO:** Prime Therapeutics Management Prior Authorization Program  
Attn: CP – 4201  
P.O. Box 64811  
St. Paul, MN 55164-0811