CVS CAREMARK

Fax Referral To: 800-323-2445
Phone: 866-278-6634

Aranesp® (darbepoetin alfa)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION
*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**
Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ 285.21 Anemia of chronic renal failure ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Is patient continuing therapy with the requested drug? ☐ Yes ☐ No

Requests will only be approved for 2 months at a time. An additional request for those patients who require treatment beyond 2 months will have to be submitted and the following criteria met, in addition to the above.

- Does Hgb exceed 12g/dl? ☐ Yes ☐ No • Please specify current Hgb _____ g/dl
- Are iron stores (including transferrin saturation and ferritin) adequately maintained and monitored periodically during therapy? ☐ Yes ☐ No
- Patient has tried, failed or is intolerant to Procrit in the previous 180 days? ☐ Yes ☐ No
- Is the patient's anemia related to a non-approved cause (e.g., iron deficiency, folate deficiency, vitamin B12 deficiency, hemolysis, gastrointestinal bleeding or other active or occult bleeding, sickle cell anemia, thalassemia, or porphyria)? ☐ Yes ☐ No

ALL of the following criteria must be met:

- Patient has hematocrit (HCT) / hemoglobin (Hgb) levels less than 32% / 10g/dl, prior to initiation of therapy (unless otherwise specified below). ☐ Yes ☐ No
- The patient's iron status, prior to and during therapy, including transferrin saturation and serum ferritin is evaluated with transferrin saturation at least 20% and ferritin at least 100ng/ml prior to initiation of therapy. ☐ Yes ☐ No
- For patients with uncontrolled hypertension, blood pressure is adequately controlled before initiation of therapy and closely monitored and controlled during therapy. ☐Y ☐N

ONE of the following criteria must be met:

- Patient has anemia of chronic renal failure and one of the following: ☐ Yes ☐ No
  - Patient is on dialysis [end-stage renal disease (ESRD)] ☐ Yes ☐ No
  - Patient is on dialysis with <10g/dl ☐ Yes ☐ No
- Treatment of anemia induced by chemotherapy known to produce anemia, in patients with a diagnosis of any of the following: ☐ Yes ☐ No
  - Cancer, **excluding** acute leukemia ☐ Yes ☐ No
- Patient has Myelodysplastic syndrome with endogenous erythropoietin level is ≤ 500mUnits/ml ☐ Yes ☐ No

If the patient is currently on Aranesp:

- Has the patient had a sudden loss of response with severe anemia and low reticulocyte count? ☐ Yes ☐ No
- Is the Aranesp dosage being increased more frequently than once per month? ☐ Yes ☐ No
- Has it been ≥ 8 weeks since chemotherapy was completed? ☐ Yes ☐ No
- Has the patient demonstrated a response to Aranesp therapy? ☐ Yes ☐ No
- Are iron stores monitored periodically? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Aranesp® (darbepoetin alfa)	☐ 25mcg ☐ 40mcg ☐ 60mcg ☐ 100mcg ☐ 150mcg ☐ 200mcg ☐ 300mcg ☐ 500mcg ☐ Autoinjector ☐ Prefilled Syringe ☐ Vial	☐ Inject the entire contents of autoinjector syringe subcutaneously once *every other week* ☐ Inject the entire contents of autoinjector syringe subcutaneously once a week.		

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)