



**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 **Today's date:** _____ **Date needed:** _____

Dispensing Provider for Medication Request: Aetna Specialty Pharmacy® (ASRx) or Other: _____
Phone: _____ Fax: _____ **TIN:** _____ **PIN:** _____

If ASRx dispensing, ship to: Doctor's office Patient Other: _____ Phone: _____

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID #: _____ Carrier Name: _____
Insured:	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> 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:	

D. DIAGNOSIS & CLINICAL INFORMATION: Please indicate primary ICD-9 code and specify where applicable (*). Answer all clinical questions.

<input type="checkbox"/> 042.0 Human immunodeficiency virus (HIV)	<input type="checkbox"/> _____ Anemia of chronic illness (285.21 or 285.29)
<input type="checkbox"/> 079.53 Human immunodeficiency virus, type 2 [HIV-2]	*Primary ICD-9: _____ 8-week auth.
<input type="checkbox"/> 070.41 Hepatitis C acute or unspecified with hepatic coma	<input type="checkbox"/> _____ *Chronic kidney disease (585.1-585.9) 16-week auth.
<input type="checkbox"/> 070.44 Chronic Hepatitis C with hepatic coma	<input type="checkbox"/> 585.6 ESRD with dialysis 16-week auth.
<input type="checkbox"/> 070.51 Acute or unspecified Hepatitis C w/o mention of hepatic coma	<input type="checkbox"/> 776.6 Anemia of prematurity (Birth weight of _____ grams, gestational age of _____ weeks) 6-week auth.
<input type="checkbox"/> 070.54 Chronic Hepatitis C w/o mention of hepatic coma	<input type="checkbox"/> Patient scheduled to undergo high-risk surgery who is at increased risk of or intolerant to transfusions 8-week auth.
<input type="checkbox"/> 070.70 Unspecified viral Hepatitis C w/o hepatic coma	<input type="checkbox"/> _____ *Malignant neoplasm (140.0-204.91) 8-week auth.
<input type="checkbox"/> 070.71 Unspecified viral Hepatitis C with hepatic coma	<input type="checkbox"/> _____ *Myelodysplastic syndrome (238.72-238.75) 12-week auth.
Is patient currently on Ribavirin? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other: _____
Is patient on chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, date of last treatment: _____	
If No, is he/she scheduled for chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, expected start date: _____	

E. LAB VALUES

F. PRESCRIPTION INFORMATION - To be completed as a prescription order if Aetna Specialty Pharmacy is Dispensing Provider

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 precert (must be drawn within past 12 months) • Is the patient receiving iron supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please select medication: <input type="checkbox"/> Aranesp <input type="checkbox"/> Epogen <input type="checkbox"/> Procrit Please check appropriate code: <input type="checkbox"/> Q4081 (ESRD); <input type="checkbox"/> J0886 (ESRD); <input type="checkbox"/> J0882 (ESRD) <input type="checkbox"/> J0881 (non-ESRD); <input type="checkbox"/> J0885 (non-ESRD) For Hgb greater than 12 g/dL please indicate the Dosage Change: From _____ To _____ Frequency _____ Date of change _____
	Dose/Route/Freq: _____ Refills: _____ 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 ≤ 12g/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 >12 but ≤14g/dL, dose should be 10% less than previously administered dose.

When initiating therapy (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:

***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: _____