Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Aranesp

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Has the patient been assessed for iron deficiency anemia and have found to have adequate iron stores (defined as a serum transferrin saturation [TSAT] level greater than or equal to 20% within the prior 3 months) or are they receiving iron therapy? Please attach labs/documentation.

☐ Yes ☐ No

Q2. Is the patient using Aranesp concomitantly with other erythropoiesis stimulating agents?

☐ Yes ☐ No

Q3. Request type:

☐ Initial Therapy - Go to 4 ☐ Continuation of Therapy - Go to 5

Q4. Is the medication being prescribed for one of the following indications with labs specified below attached?
a. Treatment of anemia due to chronic kidney disease with pretreatment hemoglobin less than 10 g/dL
b. Treatment of anemia due to myelosuppressive chemotherapy with non-myeloid malignancy and pretreatment hemoglobin less than 10 g/dL

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Patient Name:	**Prescriber Name:**

c. Treatment of anemia in myelodysplastic syndrome in members with pretreatment hemoglobin less than 10 g/dL whose pretreatment serum erythropoietin (EPO) level is less than 500 mU/mL
d. Treatment of anemia in members who will not/cannot receive blood transfusions (e.g., religious beliefs) with pretreatment hemoglobin less than 10 g/dL
e. Treatment of myelofibrosis-associated anemia with pretreatment hemoglobin less than 10 g/dL AND Pretreatment serum erythropoietin (EPO) level less than 500 mU/mL
f. Treatment of anemia due to cancer in members who have cancer and are undergoing palliative treatment

☐ Yes ☐ No

Q5. For continuation of therapy after at least 12 weeks of Aranesp treatment for the below diagnoses, is there documentation showing a response to treatment with a rise in hemoglobin of greater than or equal to 1 g/dL? OR the patient has completed less than 12 weeks of ESA treatment and has not yet responded with a rise in hemoglobin of greater than or equal to 1 g/dL. Please attach labs/documentation.

☐ Yes ☐ No

Q6. Is the patient's current hemoglobin less than 12 g/dL?

☐ Yes ☐ No

Q7. Is the patient continuing treatment of anemia due to cancer and is undergoing palliative treatment?

☐ Yes ☐ No

Q8. Additional Information:

_____ _____

Prescriber Signature Date

v2025