

Physician Request Form for Aranesp®

Fax non-urgent requests to PerformRx Pharmacy Services at 866-369-6038 or urgent requests to 866-533-5491. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call 866-533-5490. Form must be completed for processing.



Patient Name: _____ Member ID: _____
Address: _____ Apt # or Suite #: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Birth Date: _____
Physician Name: _____ NPI #: _____
Address: _____ Apt # or Suite #: _____
City: _____ State: _____ Zip Code: _____
Contact Person: _____ Phone #: _____ Fax #: _____
Physician Signature: _____

Deliver to Patient's Home Deliver to Physician's Office Pick-up at Local Pharmacy (Name/Phone #) _____

Is the member/patient currently residing in a Long-Term Care (LTC) facility? (please check) Yes No

To be Administered From: _____ to _____ OR on: _____ Date of Request: _____

Is the patient on iron, folate and/or vitamin B12 therapy? (please check) Yes No If yes, specify: _____

LABS (Please submit a copy of the most recent labs and/or complete the following)- (lab values should be within 30 days of request)

Hb: _____ g/dL Hct: _____ % Date of labs: _____ Vit B12: _____ Folate: _____ Date of labs: _____

TSAT: _____ % (TSAT >20% and Ferritin >100 required to avoid functional iron deficiency) Ferritin: _____ ng/mL Date of labs: _____

Weight: _____ lbs or _____ kg (i.e. wt in lbs/2.2 = wt in kg)

GFR _____ ml/min/1.73m² Has the patient met the criteria for CKD (as defined by KDOQI) for > 3 months? (please check) Yes No

COMPLETE APPROPRIATE DIAGNOSES AND DOSING SECTION:

A. Chronic Renal Failure (CRF) Approvable Dosing for calculating INITIAL Aranesp® therapy and Re-authorization of therapy

1. Initial Therapy Calculated Dose= Weight _____ kg * 0.75mcg/kg: _____ (See table 1 below)

Table 1. Please check the corresponding prescription of Aranesp® based on the above initial calculated dose:

Table with 4 columns: Prescription for calculated dose, Calculated Dose, Prescription for calculated dose, Calculated Dose. Rows include options like 25 mcg sc every 2 weeks, 40 mcg sc every 2 weeks, 100 mcg sc every 4 weeks, 60 mcg sc every 2 weeks, 150 mcg sc every 4 weeks, 100 mcg sc every 2 weeks, 200 mcg sc every 3 weeks, and Other Rx dose.

2. Re-authorization request: Dose: _____ Sig: _____

B. Changing a patient ALREADY ON Procrit® THERAPY to Aranesp® Dx of Type of Anemia (HIV, CA, CRF, etc.) _____

Table 2. Please check current Procrit® dose to select appropriate Aranesp® prescription:

Table with 4 columns: Previous Total Procrit® dosage (U/wk), Requested Aranesp® prescription, Previous Total Procrit® dosage (U/wk), Requested Aranesp® prescription. Rows include dosage ranges like <4,999, 2500-4,999, 5,000-10,999, 11,000-17,999 and corresponding Aranesp® prescriptions like 12.5mg Q 2 weeks, 25mcg Q 2weeks, 25mcg Q week, 40mcg Q week.

To change frequency to Q 2 weeks:

- 1. Multiply the total dose per week of Procrit® by 2 = _____ Units
2. With that calculated value, use the above table to determine the every 2 week dose of Aranesp®
Ex. Total weekly dose of Procrit® = 10,000 U. Multiply 10,000 U by 2 = 20,000 U. This falls in the range (18,000-33,999) in the table which converts to Aranesp® 60 mcg Q 2 weeks.
 Dose _____ Q 2 weeks

C. Treatment Request for Cancer (CA) Related Anemia. Check prescription accordingly.

NOTE: All patients must be advised of the benefits/risks of ESA treatment and must receive the Aranesp Medication Guide. ESAs are not indication for patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure.

- Is the patient currently receiving myelosuppressive chemotherapy? (please check) Yes No
 Initial treatment prescription: 200mcg every 2 weeks. (Only approvable initial dose for treatment of cancer anemia)
 Reauthorization prescription: 200mcg every 2 weeks: No of Refills _____ Or Number of Doses Requested _____
 Other prescription: Dose: _____ Sig: _____

D. Diagnosis of Anemia due to causes Other Than Cancer and Chronic Renal Failure (i.e. HIV): _____

Initial or re-authorization of the requested dose: _____ Sig: _____