

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
ARANESP (darbepoetin alfa)

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- Diagnosis of anemia associated with renal failure or chemotherapy; OR
- Diagnosis of Hepatitis C and being treated with ribavirin.
- No GI bleeding
- Hematocrit <33% supported by lab work done within the past 3 months (**FAX COPY OF LAB-WORK**)
- Hemoglobin <11% supported by lab work done within the past 3 months (**FAX COPY OF LAB-WORK**)
- Prescribing authority limited to hematologist, oncologist, nephrologist, gastroenterologist, and infectious disease specialists or based upon a consult with one of these specialists.

NOTE: Prior authorization will not be given to patients on dialysis.

INITIAL AUTHORIZATION: 6 Months

RE-AUTHORIZATION: No GI bleeding, not on dialysis. Hematocrit <39% , Hemoglobin 11-13 supported by lab data done within the past 3 months (**FAX COPY OF LAB-WORK**).

9/13/10