

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

Patient name: _____ Medicaid or SS# _____
Physician Name: _____ Contact person: _____
Phone#: _____ Ext. and opt. _____ Fax# _____
Pharmacy _____ Pharmacy Phone#: _____
Diagnosis _____

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 (801) 536-0477**

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.

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**)