Aranesp, Epogen, Mircera, Procrit, Retacrit

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Aranesp ☐ Epogen ☐ Mircera ☐ Procrit ☐ Retacrit Other (please specify):

Strength: Dosing schedule: J-Code: ICD10:

Number of Injections per month: Expected duration: Patient's weight:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):
Is this infusion occurring in a facility affiliated with hospital outpatient setting? Yes ☐ No ☐
If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? Yes ☐ No ☐
NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting.

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Data:
Is this drug being used to treat anemia related to any of the following?
☐ acute hemorrhage or blood loss
☐ chemotherapy
☐ chronic kidney disease (CKD) WITH dialysis
☐ chronic kidney disease (CKD) WITHOUT dialysis
☐ hepatitis C treatment
☐ myelodysplastic syndrome (MDS)
☐ myelofibrosis (MF)
☐ preoperative anemia
☐ zidovudine treatment for HIV-infected individual
☐ NOT treating anemia
☐ cause of anemia not listed above
☐ none of the above (please specify):

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples or is a restart of therapy, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy- start date:

(if CKD, hepatitis C, preoperative, zidovudine) Which of the following applies to your patient?
☐ patient's serum ferritin is 100 mcg/L or higher
☐ patient's serum transferrin saturation is 20% or higher
☐ neither of the above
☐ unknown

(if chemo, MDS, or MF) Which of the following applies to your patient?
☐ Patient's serum ferritin is 30 mcg/L or higher
☐ Patient's serum transferrin saturation is 20% or higher
☐ neither of the above
☐ unknown

(if neither/unknown to either of the 2 previous questions) Please provide current lab levels to support that your patient has adequate iron stores (transferrin, ferritin, and transferrin saturation), including dates of draws.
_____

What is/was your patient's PRETREATMENT hemoglobin level (g/dL) [prior to use of epoetin (Aranesp, Epogen, Mircera, Procrit, Retacrit)]? _____

(if **chemotherapy**, **MDS** or **MF**, continued therapy) Please provide a hemoglobin level (g/dL) for your patient taken within the first 12 weeks of therapy with epoetin and include the date the lab was drawn.

(if **CKD** or **preoperative**, continued therapy) Please provide a recent hemoglobin level (g/dL) for your patient while on therapy with epoetin and include the date the lab was drawn.

(if **hepatitis C** or **zidovudine**, continued therapy) Please provide a hemoglobin level (g/dL) for your patient taken within the first 6 months of therapy with epoetin and include the date the lab was drawn.

(if **chemotherapy**) Is your patient being treated for either AML or CML (acute myeloid leukemia or chronic myeloid leukemia)? ☐ Yes ☐ No
(if **chemotherapy**) Is your patient receiving palliative chemotherapy? ☐ Yes ☐ No
(if **chemotherapy**) Is your patient currently receiving myelosuppressive chemotherapy treatments? ☐ Yes ☐ No
(if yes) Is chemotherapy expected to continue for at least 2 more months (8 weeks)? ☐ Yes ☐ No
How many more weeks of chemotherapy are planned? _____

(if **hepatitis C**) How many more weeks of hepatitis C therapy is your patient expected to receive? _____
(if **hepatitis C**) Is your patient currently receiving ribavirin in combination with either interferon alfa (Intron A) or peginterferon alfa (Pegasys, PegIntron)? ☐ Yes ☐ No

(if **MDS** or **MF**) What is/was your patient's PRETREATMENT erythropoietin level [prior to use of epoetin (Aranesp, Epogen, Procrit, Retacrit)]? _____

(if **MDS** or **MF**, continued therapy) What is your patient's current hemoglobin level and date of lab draw? _____

(if **preoperative**, continued therapy) Please explain the clinical rationale for your patient to continue epoetin, including surgery date.

(if **preoperative**) Is anemia secondary to autologous blood donation (patient self-donated blood)? ☐ Yes ☐ No
(if preoperative) Is your patient not willing or not able to donate autologous blood prior to surgery? ☐ Yes ☐ No
(if **preoperative**) Is your patient scheduled for elective surgery? ☐ Yes ☐ No
(if **preoperative**) Is your patient scheduled for cardiac or vascular surgery? ☐ Yes ☐ No
(if no/unknown) What kind of surgery is your patient scheduled to undergo? _____

(if zidovudine) Is your patient currently receiving zidovudine (Retrovir) treatment? ☐ Yes ☐ No

Additional Pertinent Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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