Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Aranesp (darbepoetin alfa) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 weeks; Continuation- 12 weeks

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Aranesp (darbepoetin alfa).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Provider Information

Is the prescriber a nephrologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: ____

Provider Name: ______________________________ Specialty: __________________________ NPI: ____________________

Provider Address: ____

Provider Phone #: __________________________Provider Fax #: ___________________________

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: ____

Pharmacy Phone #_______________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____
Sig: ____

Drug 2: Name/Strength/Formulation: ____
Sig: ____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _________________________________
2. Indicate the patient's diagnosis for the requested medication: ____

Clinical Criteria:

1. Member has contraindication, intolerance or failure to preferred epoetin alfa product (i.e., Procrit), **AND**
   □ No □ Yes

2. Member has a diagnosis of one of the following:
   - ESRD or chronic kidney disease of at least stage 3 (eGFR <60mL/min/1.73 m2)
   - Chemotherapy-induced anemia in non-myeloid malignancies
   - Cancer patients who are undergoing palliative treatment
   - Myelodysplastic syndrome (MDS)
   - Chronic hepatitis C
   - Anemia in patients whose religious beliefs forbid blood transfusions
   - Patient taking chemotherapeutic medications when medically necessary for non-cancer diagnosis or following stem cell transplantation and associated immunosuppression

   □ No □ Yes

   AND

3. Hemoglobin <10 g/dL within 7 days (unless medical documentation showing need – e.g., severe angina, severe pulmonary distress, severe hypertension) **AND**
   □ No □ Yes

4. TSAT ≥20% unless ferritin >500, then may be approved with TSAT <20%, **AND**
   □ No □ Yes

5. B12 and folate NOT deficient, **AND**
   □ No □ Yes

6. Member does not have uncontrolled hypertension, **AND**
   □ No □ Yes

7. Member is not using in combination with another erythropoiesis stimulating agent
   □ No □ Yes

For continuation of therapy, please respond to additional questions below:

1. Target hemoglobin <12 g/dL within 7 days **AND**
   No □ Yes

2. Member shows clinical response to ESA therapy – increase in HGB of at least 1g/dL after at least 12 weeks of therapy
   No □ Yes

7 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

____

____

____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**
Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility	