Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Aranesp

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Has the patient been assessed for iron deficiency anemia and have found to have adequate iron stores (defined as a serum transferrin saturation [TSAT] level greater than or equal to 20% within the prior 3 months) or are they receiving iron therapy? Please attach labs/documentation.

☐ Yes ☐ No

Q2. Is the patient using Aranesp concomitantly with other erythropoiesis stimulating agents?

☐ Yes ☐ No

Q3. Request type:

☐ Initial Therapy - Go to 4 ☐ Continuation of Therapy - Go to 5

Q4. Is the medication being prescribed for one of the following indications?
A) Treatment of anemia due to chronic kidney disease with pretreatment hemoglobin less than 10 g/dL
B) Treatment of anemia due to myelosuppressive chemotherapy with nonmyeloid malignancy and pretreatment hemoglobin less than 10 g/dL
C) Treatment of anemia in myelodysplastic syndrome in members with pretreatment hemoglobin

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less than 10 g/dL whose pretreatment serum erythropoietin (EPO) level is less than 500 mU/mL
D) Treatment of anemia in members whose religious beliefs forbid blood transfusions with pretreatment hemoglobin less than 10 g/dL
E) Treatment of anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis with Pretreatment hemoglobin less than 10 g/dL AND Pretreatment serum EPO level less than 500 mU/mL
F) Treatment of anemia due to cancer in members who have cancer and are undergoing palliative treatment

☐ Yes ☐ No

Q5. For continuation of therapy for the below diagnoses, is there documentation showing a response to treatment with a rise in hemoglobin of greater than 1 g/dL?

A) Continued treatment of anemia due to chronic kidney disease with current hemoglobin less than 12 g/dL.
B) Continued treatment of anemia due to myelosuppressive chemotherapy with nonmyeloid malignancy and current hemoglobin less than 12 g/dL.
C) Continued treatment of anemia in myelodysplastic syndrome with current hemoglobin less than 12 g/dL
D) Continued treatment of anemia in patients whose religious beliefs forbid blood transfusions with current hemoglobin less than 12 g/dL
E) Continued treatment of anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis with current hemoglobin less than 12 g/dL
F) Continued treatment of anemia due to cancer in patients who have cancer and are undergoing palliative treatment

☐ Yes ☐ No

Q6. Additional Information:

Prescriber Signature

Date

v2025