Physician Request Form for Aranesp®
Fax to Pharmacy Services at **855-811-9332**, or to speak to a Representative, call **888-602-3741**. *Form must be completed for processing.*

AmeriHealth Caritas District of Columbia

Patient Name: _____ Patient ID #: _____
Address: _____ Apt # or Suite #: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Birth Date: _____

Physician Name: _____ NPI #: _____
Address: _____ Apt # or Suite #: _____
City: _____ State: _____ Zip Code: _____
Contact Person: _____ Phone #: _____ Fax #: _____
Physician Signature: _____

❑ **Deliver to Patient's Home** ❑ **Deliver to Physician's Office** ❑ **Pick-up at Local Pharmacy (Name/Phone #**_____
To be Administered From: _____ to _____ OR on: _____Date of Request: _____

Is the patient on iron, folate and/or vitamin B12 therapy? (please check) ❑ **Yes** ❑ **No** If yes, specify: _____

LABS *(Please submit a copy of the most recent labs and/or complete the following)- (lab values should be within 30 days of request)*

Hb: _____ **g/dL Hct:** _____**% Date of labs:** _____**Vit B12:**_____ **Folate:** _____ **Date of labs:** _____

TSAT: _____**%** (TSAT >20% and Ferritin >100 required to avoid functional iron deficiency) **Ferritin:** _____ **ng/mL Date of labs:** _____

Weight:_____ **lbs or** _____ **kg (i.e. wt in lbs/2.2 = wt in kg)**

GFR _____ **ml/min/1.73m²** Has the patient met the criteria for CKD (as defined by KDOQI) for > 3 months? (please check) ❑ Yes ❑ No

COMPLETE APPROPRIATE DIAGNOSES AND DOSING SECTION:

❑ **A. Chronic Renal Failure (CRF) Approvable Dosing for calculating INITIAL Aranesp® therapy and Re-authorization of therapy**

1. **Initial Therapy Calculated Dose=** Weight _____ kg * 0.75mcg/kg: _____ **(See table 1 below)**

Table 1. Please check the corresponding prescription of Aranesp® based on the above initial calculated dose:

Prescription for calculated dose	Calculated Dose	Prescription for calculated dose	Calculated Dose
❑ 25 mcg sc every 2 weeks	1-34 mcg	❑ 150 mcg sc every 4 weeks	71-84 mcg
❑ 40 mcg sc every 2 weeks	35-44 mcg	❑ 100 mcg sc every 2 weeks	85-115 mcg
❑ 100 mcg sc every 4 weeks	45-54 mcg	❑ 200 mcg sc every 3 weeks	116-135 mcg
❑ 60 mcg sc every 2 weeks	55-70 mcg	❑ Other Rx dose: Sig:	

2. **Re-authorization request:** Dose: _____ Sig: _____

❑ **B. Changing a patient ALREADY ON Procrit® THERAPY to Aranesp® Dx of Type of Anemia (HIV, CA, CRF, etc.)**_____

Table 2. Please check current Procrit® dose to select appropriate Aranesp® prescription:

Previous Total Procrit® dosage (U/wk)	Requested Aranesp® prescription	Previous Total Procrit® dosage (U/wk)	Requested Aranesp® prescription
❑ <4,999	12.5mg Q 2 weeks	❑ 18,000-33,999	60mcg Q week
❑ 2500 - 4,999	25mcg Q 2weeks	❑ 34,000-89,999	100mcg Q week
❑ 5,000-10,999	25mcg Q week	❑ >90,000	200mcg Q week
❑ 11,000-17,999	40mcg Q week		

To change frequency to Q 2 weeks:

1. Multiply the total dose per week of Procrit® by 2 = _____Units
2. With that calculated value, use the above table to determine the every 2 week dose of Aranesp®
   Ex. Total weekly dose of Procrit® = 10,000 U. Multiply 10,000 U by 2 = 20,000 U. This falls in the range (18,000-33,999) in the table which converts to Aranesp® 60 mcg Q 2 weeks.

❑ Dose _____ Q 2 weeks

❑ **C. Treatment Request for Anemia in Cancer Patients on Chemotherapy Check prescription accordingly.**

Is the Patient currently receiving chemotherapy? {Circle one} **YES** **NO**

Please Specify Chemotherapy and Date(s) of treatment: _____

Does patient have any anemia risk factors (i.e. Co morbidities – CHF, CAD, highly myelosuppressive chemo treatment, radiation therapy, etc)?

{Circle one} ***YES*** ***NO*** *If yes, please specify*_____

❑ Initial treatment prescription: 200mcg every 2 weeks, (Only approvable initial dose for treatment of anemia due to chemotherapy)

❑ Reauthorization prescription: ❑ 200mcg every 2 weeks: No of Refills_____Or Number of Doses Requested_____

❑ Other prescription: Dose: _____ Sig: _____

❑ **D. Diagnosis of Anemia due to Causes Other Than Cancer and Chemotherapy Related Anemia and Chronic Renal Failure (i.e. HIV):** _____

❑ Initial or re-authorization of the requested dose: _____Sig. _____

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