



RxAmerica
 221 N. Charles Lindbergh Dr.
 Salt Lake City, UT 84122-9902
 Phone: (866) 453-1999 Fax: (866) 514-1715

Minnesota Health Care Programs Prior Authorization Request Form
 Aranesp® (darbepoetin alfa)

●●● Only one medication request per form ●●● All fields must be complete and legible for review ●●●

<input type="checkbox"/> STANDARD REVIEW (72 HOURS)		<input type="checkbox"/> EXPEDITED REVIEW (24 HOURS)	
By selecting the expedited review and signing this form below, I certify that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.			
PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name:		Prescriber Name and Specialty:	
Member ID#:		DEA #:	
Sex (circle): Male Female		Office Phone:	
Date of Birth:		Office Fax:	
Patient Phone:		Contact Person:	
PHARMACY INFORMATION			
Pharmacy Name:	NABP#:	PHARMACY PHONE NO:	PHARMACY FAX NO:
DIAGNOSIS AND MEDICAL INFORMATION			
Medication:	Strength and Route of Administration:	Frequency:	
<input type="checkbox"/> New Prescription – OR – Date Therapy Initiated: / /	Expected Length of Therapy:	Quantity:	
Height & Weight:	Drug Allergies:	Diagnosis Related to Medication Requested:	
Rationale for Prior Authorization Request			
Medical Justification for Aranesp			
1. Is the drug being used for the treatment of anemia for a patient with CRF and on dialysis?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
2. Is the drug being used for the treatment of anemia due to concomitant chemotherapy?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
3. Is the drug being used for the treatment of anemia due to myelodysplastic syndrome?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
4. Is the drug being used for the treatment of anemia due to heart failure?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Current Hemoglobin level: _____			
Prescriber's Signature:		Date:	