MIRCERA® (methoxy polyethylene glycol-epoetin beta) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Oncologist** ☐ **Nephrologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: MIRCERA (methoxy polyethylene glycol-epoetin beta) **Dose:** _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For ALL Requests (clinical documentation required for all requests):

☐ Yes ☐ No Does the patient have a documented diagnosis of anemia due to chronic kidney disease (CKD)?
☐ Yes ☐ No Will the requested drug be used concomitantly with other erythropoiesis stimulating agents (ESAs)?
☐ Yes ☐ No Has the patient received erythropoiesis stimulating agent (ESA) therapy in the previous month (within 30 days of request)?

For Initiation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Does the patient have a contraindication, intolerance or ineffective response to Procrit?
☐ Yes ☐ No Does the patient have a contraindication, intolerance or ineffective response to Aranesp?
☐ Yes ☐ No Has the patient been assessed for iron deficiency anemia?
Please indicate the patient's most recent serum transferrin saturation (TSAT) level and date of test: ____% Date of test: ____/____/____
☐ Yes ☐ No Is the patient receiving iron therapy?
Please indicate the patient's pretreatment hemoglobin (Hgb) level (exclude values due to a recent transfusion): _____ Date of test: ____/____/____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient completed at least 12 weeks of erythropoiesis stimulating agent (ESA) therapy?

→ Please indicate the number of weeks completed: _____

→ ☐ Yes ☐ No Has the patient been assessed for iron deficiency anemia?

Please indicate the patient's most recent serum transferrin saturation (TSAT) level and date of test: _____%

Date of test: ____/____/____ ☐ Yes ☐ No Is the patient receiving iron therapy?

☐ Yes ☐ No At any time since the patient started ESA therapy, has the patient's Hgb increased by 1 g/dL or more?

Please indicate the patient's current hemoglobin (Hgb) level (exclude values due to a recent transfusion): _____

Date of test: ____/____/____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.