



**Medical Necessity Determination Request Form**  
**EPOETIN ALPHA (Epogen/Procrit) DARBEPOETIN ALPHA (Aranesp)**  
**Phone: 1-866-529-8348 Fax: 1-866-337-2058**  
**Online at [www.carecorenational.com](http://www.carecorenational.com) to check eligibility status and to enter your request**

Date : \_\_\_/\_\_\_/\_\_\_ Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Patient information:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Patient ID# \_\_\_\_\_

**Ordering Physician:**

Name \_\_\_\_\_ Provider Address/City/State/Zip: \_\_\_\_\_

Will this medication be administered in this Physician's office?  YES Complete the following  NO If No - complete the Rendering Site section

Phone#: \_\_\_\_\_ Fax #: \_\_\_\_\_ UPIN # : \_\_\_\_\_ Tax ID#: \_\_\_\_\_

**Rendering Site:**

Facility Name: \_\_\_\_\_  Freestanding Dialysis Center  Other \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax #: \_\_\_\_\_ Medicare ID# \_\_\_\_\_ Tax ID: \_\_\_\_\_

**MEDICATION REQUESTED: (check one)**

Doses allowed in 8 weeks

- |                                                                                                                    |    |
|--------------------------------------------------------------------------------------------------------------------|----|
| <input type="checkbox"/> J0881 Darbepoetin alfa injection; non-ESRD, 1 mcg ( <i>Aranesp</i> )                      | 4  |
| <input type="checkbox"/> J0882 Darbepoetin alfa injection; for ESRD on dialysis, 1 mcg ( <i>Aranesp</i> )          | 4  |
| <input type="checkbox"/> J0885 Epoetin alfa injection; non-ESRD, 1000 units ( <i>Epogen, Procrit</i> )             | 8  |
| <input type="checkbox"/> J0886 Epoetin alfa injection: for ESRD on dialysis, 1000 units ( <i>Epogen, Procrit</i> ) | 24 |
| <input type="checkbox"/> Q4081 Epoetin alfa injection: for ESRD on dialysis, 100 units ( <i>Epogen, Procrit</i> )  | 24 |

**Requested date(s) of administration for this medication:** \_\_\_/\_\_\_/\_\_\_

*If services have been rendered, document all dates for which approval is requested on a separate page and submit corresponding hg level or Flow sheet for each date.*

**CLINICAL INDICATIONS FOR USE OF THIS MEDICATION (complete all that apply):**

**1. DIAGNOSIS RELATIVE TO THE TYPE OF ANEMIA TREATED:**

ICD-9 code \_\_\_\_\_ Description: \_\_\_\_\_

**2. UNDERLYING CAUSE OF THE ANEMIA WHICH REQUIRES ESA TREATMENT:**

Chronic Renal Failure: ICD-9 code \_\_\_\_\_ Description: \_\_\_\_\_

Is the patient receiving medication with dialysis?  YES  NO If NO what is the creatinine clearance or GFR \_\_\_\_\_

Cancer Treatment: Cancer Type: \_\_\_\_\_ ICD-9 code \_\_\_\_\_ Description: \_\_\_\_\_

Currently on myelosuppressive chemotherapy/biologics?  NO  YES Date of last Chemotherapy \_\_\_/\_\_\_/\_\_\_ Agent: \_\_\_\_\_

Surgery scheduled with expected blood loss: Specify procedure: \_\_\_\_\_

Other indication; specify: \_\_\_\_\_ ICD9 \_\_\_\_\_ Description: \_\_\_\_\_

Does patient have severe heart or lung disease limiting functional capacity?  No  Yes if yes, specify: \_\_\_\_\_

**3. Has the patient received treatment with any ESA agent prior to this request?**  No  Yes *If Yes; provide the following information:*

- Date the medication was **initially** administered (first lifetime treatment): \_\_\_/\_\_\_/\_\_\_
- Date that this medication was **last** administered: \_\_\_/\_\_\_/\_\_\_
- Hemoglobin level **before** initial treatment (pretreatment): \_\_\_\_\_ Test Date: \_\_\_/\_\_\_/\_\_\_
- **Highest Hemoglobin within first 16 weeks** of ESA therapy: \_\_\_\_\_ Test Date: \_\_\_/\_\_\_/\_\_\_

**4. Hg level just prior to date this service is requested:** Hgb: \_\_\_\_\_ Date of test: \_\_\_/\_\_\_/\_\_\_ *(see requested date of administration)*

*If the Hg level is over 12.0, please submit medication tapering information with this request.*

**5. Are iron stores documented to rule out other causes for anemia?** ( i.e. Iron, TIBC, Ferritin)  NO  YES

**6. Additional Information:** \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_