Blue Cross Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Aranesp® (darbepoetin alpha)

BCBSVT and TVHP Fax # (888)–255-1006

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request ______________ Patient Name: _________________________

Member ID#:___________________ Date of Birth: ____________________________

Provider Name:_________________ Provider Phone: ________________________

Provider Fax: ____________________ PCP Name: ____________________________

INDICATIONS FOR USE	YES	NO
1. Anemic patients with chronic renal failure. *(Aranesp®)*	☐	☐
• Transferrin saturation > 20%	☐	☐
• Ferritin > 100ng/mL	☐	☐
• If a non-dialysis patient hematocrit <30%	☐	☐
• Is patients HgB greater than or equal to 12 g/dL	☐	☐
2. Anemia in non-myeloid cancer patients on chemotherapy. *(Aranesp®)*	☐	☐
• Cancer is a non-myeloid malignancy	☐	☐
• Chemotherapy is indicated for > 2 months	☐	☐
3. Does patient have Hypersensitivity to mammalian cell derived products or to human albumin?	☐	☐
4. Does patient have Uncontrolled Hypertension?	☐	☐
5. **Will Prescription be dispensed at (circle one): Provider Office Network Pharmacy**		

Initial approval will be for 4 months at which time patient should be evaluated for response. DISPENSE in no greater than 30 day supplies.

Dose:______ Frequency:_______ HgB:______ Hct:______

Transferrin Saturation_________ Ferritin__________

PRESCRIBER SIGNATURE____ DATE_____________

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

BlueCross BlueShield of Vermont
Independent Licensees of the Blue Cross and Blue Shield Association.
www.bcbsvt.com

Vermont Health Plan