

# Aranesp<sup>TM</sup>

(darbepoetin alfa)

## Insurance Verification Request Form

Amgen Reimbursement Connection<sup>®</sup>

1-800-272-9376 (telephone)

1-888-508-8090 (fax)

**Insurance Verification Only?**

Need only complete Physician, Patient, and Insurance Information sections.

\*Required if patient has a form of commercial insurance.

### PHYSICIAN/FACILITY INFORMATION

Contact/Requestor Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Facility Name \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Treating Physician's Name \_\_\_\_\_ \*Tax ID # \_\_\_\_\_  
Address \_\_\_\_\_ State License # \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Physician Specialty \_\_\_\_\_  
DEA #: \_\_\_\_\_ \*Required if patient has a form of commercial insurance.

### REQUESTOR PREFERENCES

Primary Contact for Relaying Results:  Provider Contact  Patient How would you prefer results relayed? Phone Fax No preference  
Please check all settings of care you would like researched: Office HOPD Retail Pharmacy Mail Order Specialty Pharmacy Dialysis Center

### PATIENT GENERAL INFORMATION

Patient Name \_\_\_\_\_ Patient DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yy)  
Patient Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Patient Address \_\_\_\_\_ Patient State & Zip Code \_\_\_\_\_

### PATIENT MEDICAL INFORMATION

#### Relevant Diagnosis

- Chronic Kidney Disease, Stage I (585.1)  Chronic Kidney Disease, Stage V (585.5)  Anemia of other illness (285.29)  
 Chronic Kidney Disease, Stage II (585.2)  Chronic kidney disease, unspecified (585.9)  Anemia, unspecified (285.9)  
 Chronic Kidney Disease, Stage III (585.3)  End stage renal disease (585.6)  Anemia of chronic kidney disease (285.21)  
 Chronic Kidney Disease, Stage IV (585.4)  Other (specify ICD-9 code) \_\_\_\_\_

Is patient currently receiving Epoetin alfa? Yes No Most recent Hct/Hb level (prior to initiation of Aranesp<sup>®</sup>) Hct \_\_\_\_\_ Hb \_\_\_\_\_  
Date of most recent Hct/Hb level \_\_\_\_\_ Initial Date(s) of Aranesp<sup>®</sup> injection \_\_\_\_\_  
Dose (mcg) \_\_\_\_\_ Frequency \_\_\_\_\_

### INSURANCE INFORMATION *Please check all that apply. (Complete for Medicaid and BCBS only)*

- Patient has Medicaid. If patient has Medicaid, please include the physician's Medicaid provider#: \_\_\_\_\_  
 Patient has BCBS. If patient has BCBS, please include the physician's BCBS provider#: \_\_\_\_\_

### PRIMARY INSURANCE (Please fax copy of front AND back of insurance card(s) OR provide the information below.)

Insurance Name \_\_\_\_\_ Insurance State \_\_\_\_\_  
Insurance Phone Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Provider # for this Policy \_\_\_\_\_  
Policyholder's Name \_\_\_\_\_ Policy Number \_\_\_\_\_  
Policyholder's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Group/Plan Number \_\_\_\_\_

### SECONDARY INSURANCE *Complete only if different from primary insurance information.*

Insurance Name \_\_\_\_\_ Insurance State \_\_\_\_\_  
Insurance Phone Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Provider # for this Policy \_\_\_\_\_  
Policyholder's Name \_\_\_\_\_ Policy Number \_\_\_\_\_  
Policyholder's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Group/Plan Number \_\_\_\_\_

### PRIOR TREATMENT HISTORY (Only complete if prior authorization assistance is requested.)

List of current medications \_\_\_\_\_  
For chronic kidney disease, is the patient currently on or has previously received any of the following?  Iron  Folic acid  Vitamin B12  
Iron Store Evaluation and date: Ferritin \_\_\_\_\_ TIBC \_\_\_\_\_ % Saturation \_\_\_\_\_ Serum Fe \_\_\_\_\_ Pt Weight: \_\_\_\_\_ (lb)  
Lab Values: CBC with differential \_\_\_\_\_ Transferrin Saturation \_\_\_\_\_ Serum Ferritin \_\_\_\_\_  
Additional Lab Values or other supporting information to establish medical necessity: \_\_\_\_\_

I certify that Aranesp<sup>®</sup> therapy is necessary for this patient. I will be supervising the patient's treatment accordingly.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

This verification of benefits is not a guarantee of payment by the payer, but is deemed as current coverage information as relayed by the payer to the Amgen Reimbursement Connection<sup>®</sup>. This verification cannot take the place of written policy information from the payer.