Aranesp™
(darbepoetin alfa)
Insurance Verification Request Form

Amgen Reimbursement Connection®
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®) Hct __________ Hb __________
Date of most recent Hct/Hb level ___________________ Initial Date(s) of Aranesp® 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® 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®. This verification cannot take the place of written policy information from the payer.