

AranespTM (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 (meg) _____ 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.