



**Aranesp  
Prior Authorization Request**

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435**.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to [do\\_not\\_call@cvscaremark.com](mailto:do_not_call@cvscaremark.com). An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **HPHC Provider ID:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

**Rendering Provider Info:**  Same as Requesting Provider **HPHC Provider ID:** \_\_\_\_\_  
**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Provider Tax ID:** \_\_\_\_\_

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

**Additional Demographic Information:**

Please indicate the place of service for the requested drug:

- Ambulatory Surgical  Home  Inpatient Hospital  Off Campus Outpatient Hospital
- On Campus Outpatient Hospital  Office  Pharmacy

**Drug Information:**

**Strength/Measure** \_\_\_\_\_ **Units**  ml  Gm  mg  ea  Un  
**Directions(sig)** \_\_\_\_\_ **Route of administration** \_\_\_\_\_  
**Dosing frequency** \_\_\_\_\_

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Aranesp SGM – 02/2019.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062  
Phone: 1-844-387-1435 • Fax: 1-844-851-0882 • www.caremark.com**

**Criteria Questions:**

***Please indicate patient's therapy status:***

- New start or re-start of therapy:** Please complete the following form in its entirety and fax to 866-249-6155.
- Continuation of therapy:** Please complete the following form in its entirety and fax to 866-249-6155.
- Therapy is complete:** Please check box and fax first page to 866-249-6155.
- Therapy is on hold or patient has medication available:** Please check box and fax first page to 866-249-6155.  
Please retain the following form for submission when therapy resumes or when supply of medication is low.

1. What is the patient's diagnosis?

- Anemia in chronic kidney disease (CKD)
- Anemia due to myelosuppressive chemotherapy
- Anemia in myelodysplastic syndrome (MDS)
- Anemia in patients whose religious beliefs forbid blood transfusions
- Anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis
- Anemia due to cancer
- Other \_\_\_\_\_

2. What is the ICD-10 code? \_\_\_\_\_

3. What is the patient's hemoglobin (Hgb) level? *Exclude values due to recent transfusion.*

**Pretreatment (i.e., within 30 days of request):** Hgb: \_\_\_\_\_ g/dL      Date of lab: \_\_\_\_\_

**Current (i.e., within 30 days of request):**      Hgb: \_\_\_\_\_ g/dL      Date of lab: \_\_\_\_\_

Unknown or lab not done within 30 days of request

4. Has the patient received erythropoiesis stimulating agent (ESA) therapy in the previous month (within 30 days of request)?  Yes  No *If No, skip to diagnosis section*

5. At any time since the patient started ESA therapy, has the patient's Hgb increased by 1 g/dL or more?

*If Yes, skip to diagnosis section.*  Yes  No

6. How many weeks of ESA therapy has the patient completed? \_\_\_\_\_ weeks; Document start date: \_\_\_\_\_

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*Complete the following section based on the patient's diagnosis, if applicable.*

Section A: Anemia due to Myelosuppressive Chemotherapy

7. Does the patient have a diagnosis of a non-myeloid malignancy?  Yes  No
8. Is the intent of chemotherapy to cure the cancer (as opposed to palliative management or inducing remission)?  
 Yes  No

Section B: Anemia in Primary Myelofibrosis, Post-Polycythemia Vera Myelofibrosis, or Post-Essential Thrombocythemia Myelofibrosis-**New Start ONLY**

9. Does the patient have symptomatic anemia?  Yes  No
10. What is the patient's pretreatment serum erythropoietin level? \_\_\_\_\_ mU/mL  Not available

Section C: Anemia due to Cancer

11. Is the patient undergoing palliative treatment?  Yes  No

*I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.*

X \_\_\_\_\_

Prescriber or Authorized Signature

Date (mm/dd/yy)

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