Epogen, Procrit, Retacrit

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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. 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

 Epogen, Procrit, Retacrit 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 forms in entirety and fax to 866-249-6155.
❑ Continuation of therapy: Please complete the following forms in 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. Which drug is being prescribed? ❑ Epogen ❑ Procrit ❑ Retacrit ❑ Other _____

2. What is the patient's diagnosis or reason for requesting therapy?
   - ❑ Anemia in chronic kidney disease (CKD)
   - ❑ Anemia due to myelosuppressive chemotherapy
   - ❑ Anemia in myelodysplastic syndrome (MDS)
   - ❑ Presurgical use to reduce allogeneic blood transfusions
   - ❑ Anemia in CHF
   - ❑ Anemia in rheumatoid arthritis
   - ❑ Anemia due to hepatitis C treatment
   - ❑ Anemia due to zidovudine treatment in a patient with HIV infection
   - ❑ Anemia in patients whose religious beliefs forbid blood transfusions
   - ❑ Anemia in patients with primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis
   - ❑ Anemia due to cancer
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. What is the patient's hemogoblin (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: _____

5. 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*

6. 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

7. How many weeks of ESA therapy has the patient completed? _____ weeks;
   Document start date: _____

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

Section A: Anemia due to Myelosuppressive Chemotherapy

8. Does the patient have a diagnosis of a non-myeloid malignancy? ❑ Yes ❑ No

9. Is the intent of chemotherapy to cure the cancer (as opposed to palliative management or inducing remission)? ❑ Yes ❑ No

Section B: Anemia due to Zidovudine Treatment in a Patient with HIV Infection

10. Is the patient currently receiving treatment with zidovudine-containing medications? ❑ Yes ❑ No

Section C: Anemia due to Hepatitis C Treatment

11. Is the patient currently receiving treatment with ribavirin in combination with either interferon alfa or peginterferon alfa? ❑ Yes ❑ No

Section D: Presurgical Use to Reduce Allogeneic Blood Transfusions

12. Is the patient scheduled to have an elective, noncardiac, nonvascular surgery? ❑ Yes ❑ No

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

13. Does the patient have symptomatic anemia? ❑ Yes ❑ No

14. What is the patient's pretreatment serum erythropoietin level? _____ mU/mL ❑ Not available

Section F: Anemia due to Cancer

15. 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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