Mircera

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. 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*_____________________________

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 diagnosis?
   ❑ Anemia due to chronic kidney disease (CKD) ❑ Other ___________________________________
2. What is the ICD-10 code? _____________

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. Mircera SGM – 08/2018.

3. What is the patient's hemogoblin (Hgb) level? *(Exclude values due to recent transfusion)*
Pretreatment (within 30 days of request):
Hgb: ________________ g/dL Date of lab: ________________

Current (within 30 days of request):
Hgb: ________________ g/dL Date of lab: ________________ ❑ Not applicable (new to therapy)

❑ 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 60 days of request, or received another ESA therapy within 30 days of request)?
❑ Yes ❑ No *If No, no further questions*

5. At any time since the patient started ESA therapy, has the patient's Hgb increased by 1g/dL or more?
If Yes, no further questions ❑ Yes ❑ No

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

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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