Aranesp

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

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.

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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 – 02/2023.

Criteria Questions:

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 drawn

4. Will the requested drug be used concomitantly with other erythropoiesis stimulating agents (ESAs)?
   ❑ Yes ❑ No

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 #8*.

6. At any time since the patient started ESA therapy, has the patient's Hbg increased by 1 g/dL or more?
   ❑ Yes ❑ No

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

8. Has the patient been assessed for iron deficiency anemia? ❑ Yes ❑ No

9. What is the most recent serum transferrin saturation (TSAT) level? _____ % ❑ Unknown
   Document date Serum transferrin saturation (TSAT) level obtained: _____

10. Is the patient receiving iron therapy? ❑ Yes ❑ No

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

Section A: Anemia due to myelosuppressive chemotherapy

11. Does the patient have a non-myeloid malignancy? ❑ Yes ❑ No

Section B: Anemia in myelodysplastic syndrome (MDS) or Anemia in patients with primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis

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

Section C: Anemia due to cancer

13. 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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