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: _____
Specialty: _____ NPI#: _____
Physician Office Telephone: _____ Physician Office Fax: _____
Request Initiated For: _____

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?
   ❑ Anemia in chronic kidney disease (CKD)
   ❑ Anemia due to myelosuppressive chemotherapy
   ❑ Anemia due to hepatitis C treatment
   ❑ Anemia in myelodysplastic syndrome (MDS)
   ❑ Anemia in rheumatoid arthritis
   ❑ Anemia due to cancer
   ❑ Presurgical use to reduce allogeneic blood transfusions
   ❑ 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
   ❑ Other _____

3. What is the ICD-10 code? _____

Complete the following section(s) based on the prescribed drug.

Section A: Epogen or Procrit Requests

4. The preferred product for your patient's health plan is Retacrit. Can the patient's treatment be switched to Retacrit?
   ❑ Yes - Retacrit ***Fax a new prescription to the pharmacy and skip to Section B: All Requests***
   ❑ No - Continue request for Epogen or Procrit

5. Does the patient have a documented intolerable adverse event with the preferred product, Retacrit?
   ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155

 Epogen, Procrit, Retacrit VF, ACSF SGM - 4/2023.

6. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***ACTION REQUIRED: If No, attach supporting chart note(s).***
❑ Yes ❑ No

Section B: All Requests

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

8. What is the patient's hemoglobin (Hgb) level? *(Exclude values due to recent transfusion.)*
Pretreatment (within 30 days of request):
Hgb: _____ g/dL Date of lab: _____
❑ Unknown or lab not done within 30 days of request
Current (within 30 days of request):
Hgb: _____ g/dL Date of lab: _____
❑ Unknown or lab not done within 30 days of request
❑ Not applicable (new to therapy)

9. Has the patient received erythropoiesis stimulating agent (ESA) therapy in the previous month (within 30 days of request)? ❑ Yes ❑ No *If No, skip to #12*

10. How many weeks of ESA therapy has the patient completed? _____ weeks
If less than 12 weeks, no further questions.

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

12. What is the patient's pretreatment serum erythropoietin level? _____ % ❑ Unknown or not available

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

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

15. What is the most recent serum transferrin saturation (TSAT) level? _____ % ❑ Unknown

16. Was the most recent serum transferrin saturation (TSAT) level obtained within the prior 3 months?
❑ Yes ❑ No *Indicate date of lab:* _____

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

18. Is the patient undergoing palliative treatment? ❑ Yes ❑ No

19. *If diagnosis is anemia due to hepatitis C treatment,* is the patient currently receiving treatment with ribavirin in combination with either interferon alfa or peginterferon alfa? ❑ Yes ❑ No

20. *If diagnosis is anemia due to zidovudine treatment in a patient with HIV infection,* is the patient currently receiving a zidovudine-containing medication? ❑ Yes ❑ No

21. *If diagnosis is presurgical use to reduce allogeneic blood transfusions,* is the patient scheduled to have an elective, noncardiac, nonvascular surgery? ❑ 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)**

Indicate below the physician responsible for monitoring this patient's care while on the prescribed therapy
(If additional information is needed, the physician below will be contacted):

Office Contact Name: _____ Contact Phone: _____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155