Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

Mircera

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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

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.

Aranesp and Retacrit are the preferred product when prescribing Mircera for your patient's health plan.

1. What is the patient's diagnosis?
   ❑ Anemia due to chronic kidney disease (CKD)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. The preferred product for your patient's health plan is Retacrit. Can the patient's treatment be switched to Retacrit? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - Retacrit
   ❑ No - Continue request for Mircera
4. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #6*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No
6. Does the patient have a documented inadequate response or intolerable adverse event to the preferred product? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No
7. Will the requested drug be used concomitantly with other erythropoiesis stimulating agents (ESAs)?
   ❑ Yes ❑ No

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

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

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

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

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

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)**

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