Aranesp

Prior Authorization Request

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

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.

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 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 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
   ❑ Other____
2. What is the ICD-10 code? _____________
3. What is the patient's hemogloblin (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: _______________
4. Is this request for continuation of erythropoiesis stimulating agent (ESA) therapy (i.e., patient has received ESA therapy in previous month)? ❑ Yes ❑ No *If No, skip to diagnosis section*
5. Since the initiation of ESA therapy, has the patient ever responded to treatment with a rise of Hgb greater than or equal to 1 g/dL compared to baseline? *If Yes, skip to diagnosis section* ❑ Yes ❑ No
6. How many weeks of ESA therapy has the patient completed? _________ weeks; Document start date: __________

Complete the following section based on the patient's diagnosis.

Section A: Anemia due to Myelosuppressive Chemotherapy

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

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

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

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

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

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):*

Physician's Name: ____________________________

Office Contact Person: ____________________________ Contact Phone: ____________________________