CVS caremark™ {{PANUMCODE}}

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: {{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 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)
   - ❑ Presurgical use to reduce allogeneic blood transfusions
   - ❑ Anemia in rheumatoid arthritis
   - ❑ Anemia in myelodysplastic syndrome (MDS)
   - ❑ Anemia in congestive heart failure (CHF)
   - ❑ Anemia due to hepatitis C treatment
   - ❑ 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
   - ❑ Anemia with malignancy
   - ❑ Other _____

3. What is the ICD-10 code? _____

Complete the following questions if Procrit or Epogen is being prescribed. If Retacrit is being prescribed, skip to #9.

4. The preferred products for your patient's health plan are Aranesp and Retacrit. Can the patient's treatment be switched to a preferred product?
   - ❑ Yes - Aranesp, ***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, ***fax a new prescription to the pharmacy and skip to #9***
   - ❑ No - Continue request for Procrit or Epogen

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

 Epogen, Procrit, Retacrit State Step, ACSF SGM - 1/2021.

5. Has the patient experienced a documented intolerable adverse event with Retacrit?
ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

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).***
If Yes, complete this form in its entirety and State Step Therapy section. ❑ Yes ❑ No

7. Is the product being requested for one of the following indications?
❑ Treatment of anemia due to chronic kidney disease (CKD)
❑ Treatment of anemia due to myelosuppressive chemotherapy in a cancer patient
❑ None of the above*, skip to #9*

8. Has the patient had a documented inadequate response or intolerable adverse event to treatment with Aranesp?
ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

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

10. 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)

11. *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

12. *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

13. *If diagnosis is presurgical use to reduce allogeneic blood transfusions,* is the patient scheduled to have an elective, noncardiac, nonvascular surgery? *If Yes, skip to #18* ❑ Yes ❑ No

14. Has the patient received erythropoiesis stimulating agent (ESA) therapy in the previous month (within 30 days of request)? ❑ Yes ❑ No *If No, skip to #17*

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

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

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

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

19. Does the patient have adequate iron stores or is the patient receiving iron therapy?
❑ Yes, adequate iron stores ❑ Yes, receiving iron therapy ❑ No, none of the above

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

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2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (Aranesp and Retacrit) FDA-approved for the medical condition being treated?
   ❑ Yes ❑ No *If No, please specify:* _____

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (Aranesp and Retacrit)?
   ❑ The alternate drug is contraindicated
   ❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
   ❑ The alternate drug is expected to be ineffective
   ❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
   ❑ The alternate drug is not in the patient's best interest
   ❑ The alternate drug was tried while covered by the current or the previous health benefit plan
   ❑ None of the above
   If Yes, please specify: _____

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ 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 Person: _____ Contact Phone: _____

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