Aranesp

CareFirst 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*

What is the ICD-10 code? _____

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

Criteria Questions:

1. What is the diagnosis?

❒ Anemia due to chronic kidney disease (CKD), *Continue to 2*

❒ Anemia due to myelosuppressive chemotherapy, *Continue to 2*

❒ Anemia in myelodysplastic syndrome (MDS), *Continue to 2*

❒ Anemia in patients who will not/cannot receive blood transfusions (e.g., religious beliefs), *Continue to 2*

❒ Myelofibrosis-associated anemia, *Continue to 2*

❒ Anemia due to cancer, *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Will the requested medication be used concomitantly with other erythropoiesis stimulating agents (ESAs)?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Has the patient received erythropoiesis stimulating agent (ESA) therapy in the previous month (within 30 days of request)?
❒ Yes, *Continue to 4*
❒ No, *Continue to 16*

4. Has the patient completed at least 12 weeks of Aranesp therapy? Indicate therapy start date and number of weeks completed. Start date _____MM/DD/YYY, _____ weeks completed
❒ Yes, *Continue to 6*
❒ No, *Continue to 5*

5. At any time since the patient started Aranesp therapy, has the patient's hemoglobin (Hgb) increased by 1 g/dL or more?
❒ Yes, *Continue to 7*
❒ No, *No Further Questions*

6. At any time since the patient started Aranesp therapy, has the patient's hemoglobin (Hgb) increased by 1 g/dL or more?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Has the patient been assessed for iron deficiency anemia?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. What is the most recent serum transferrin saturation (TSAT) level? Indicate percentage.

❒ Less than 20% _____, *Continue to 10*

❒ Greater than or equal to 20% _____, *Continue to 9*

❒ Unknown, *Continue to 10*

9. Was the most recent serum transferrin saturation (TSAT) level obtained within the prior 3 months? Indicate date lab was drawn. _____ MM/DD/YYYY.
❒ Yes, *Continue to 11*
❒ No, *Continue to 10*

10. Is the patient receiving iron therapy?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. What is the diagnosis?
❒ Anemia due to chronic kidney disease (CKD), *Continue to 13*
❒ Anemia due to myelosuppressive chemotherapy, *Continue to 12*
❒ Anemia in myelodysplastic syndrome (MDS), *Continue to 13*
❒ Anemia in patients who will not/cannot receive blood transfusions (e.g., religious beliefs), *Continue to 13*
❒ Myelofibrosis-associated anemia, *Continue to 13*
❒ Anemia due to cancer, *Continue to 15*

12. Does the patient have a non-myeloid malignancy?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. What is the patient's current hemoglobin (Hgb) level (exclude values due to a recent transfusion)?
❒ Less than 12 g/dL, *Continue to 14*
❒ Greater than or equal to 12 g/dL, *Continue to 14*
❒ Unknown, *Continue to 14*

14. Was the patient's current hemoglobin (Hgb) level drawn within 30 days of the request (exclude values due to a recent transfusion)? Indicate date lab was drawn.
❒ Yes _____ MM/DD/YYYY, *No further questions*
❒ No _____ MM/DD/YYYY, *No further questions*
❒ Unknown, *No further questions*

15. Is the patient undergoing palliative treatment?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

16. Has the patient been assessed for iron deficiency anemia?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. What is the most recent serum transferrin saturation (TSAT) level? Indicate percentage.
❒ Less than 20% _____ %, *Continue to 19*
❒ Greater than or equal to 20% _____ %, *Continue to 18*
❒ Unknown, *Continue to 19*

18. Was the most recent serum transferrin saturation (TSAT) level obtained within the prior 3 months? Indicate date lab was drawn. _____ MM/DD/YYYY
❒ Yes, *Continue to 20*
❒ No, *Continue to 19*

19. Is the patient receiving iron therapy?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. What is the diagnosis?
❒ Anemia due to chronic kidney disease (CKD), *Continue to 23*
❒ Anemia due to myelosuppressive chemotherapy, *Continue to 21*
❒ Anemia in myelodysplastic syndrome (MDS), *Continue to 23*
❒ Anemia in patients who will not/cannot receive blood transfusions (e.g., religious beliefs), *Continue to 23*
❒ Myelofibrosis-associated anemia, *Continue to 22*
❒ Anemia due to cancer, *Continue to 25*

21. Does the patient have a non-myeloid malignancy?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

22. What is the patient's pretreatment serum erythropoietin (EPO) level?
❒ Less than 500 mU/mL, *Continue to 23*
❒ Greater than or equal to 500 mU/mL, *Continue to 23*
❒ Unknown, *Continue to 23*

23. What is the patient's pretreatment hemoglobin (Hgb) level (exclude values due to a recent transfusion)?
❒ Less than 10 g/dL, *Continue to 24*
❒ Greater than or equal to 10 g/dL, *Continue to 24*
❒ Unknown, *Continue to 24*

24. Was the patient's pretreatment hemoglobin (Hgb) level drawn within 30 days of the request (exclude values due to a recent transfusion)? Indicate date lab was drawn.
❒ Yes _____ MM/DD/YYYY, *No further questions*
❒ No _____ MM/DD/YYYY, *No further questions*
❒ Unknown, *No further questions*

25. Is the patient undergoing palliative treatment?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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 Specialty Programs Fax: 1-855-330-1720