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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 3/16/2026
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:** _____
 _____ **NPI#:** _____ **Specialty:** _____
 _____ **Physician Office Telephone:** _____

Physician Office Address: _____

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
 - Anemia associated with alpha-thalassemia (If checked, go to 2)
 - Anemia associated with beta-thalassemia (If checked, go to 2)
 - Anemia associated with thalassemia [includes beta-thalassemia with or without alpha-globin (alpha-thalassemia) gene variants] (If checked, go to 2)
 - Anemia associated with thalassemia (includes hemoglobin E [HbE]/beta-thalassemia) (If checked, go to 2)
 - Anemia associated with thalassemia (includes alpha-thalassemia/hemoglobin H [HbH] disease) (If checked, go to 2)
 - Other, please specify: (If checked, no further questions)
2. Does the patient have a diagnosis of homozygous or heterozygous sickle hemoglobin (HbS)? **Y** **N**
3. Does the patient have a diagnosis of homozygous or heterozygous hemoglobin C (HbC)? **Y** **N**
4. Will the requested drug be used concomitantly with luspatercept-aamt (Reblozyl)? **Y** **N**
5. Is the requested drug being prescribed by or in consultation with a hematologist or a specialist in the treatment of alpha- or beta-thalassemia? **Y** **N**
6. Is the patient currently receiving treatment with the requested drug? **Y** **N**
7. Has the patient experienced benefit from therapy as evidenced by having achieved or maintained a reduction in red blood cell transfusion burden? **Y** **N**
8. Has the patient experienced benefit from therapy as evidenced by having achieved or maintained an increase in hemoglobin from baseline? **Y** **N**
9. Has the diagnosis of thalassemia (includes beta-thalassemia with or without alpha-globin [alpha-thalassemia] gene variants, hemoglobin E [HbE]/beta-thalassemia, or alpha-thalassemia/hemoglobin H [HbH] disease) been confirmed by hemoglobin electrophoresis or high-performance liquid chromatography (HPLC), OR molecular genetic testing?
 ACTION REQUIRED: If Yes, please attach laboratory report or test results.
 ACTION REQUIRED: Submit supporting documentation **Y** **N**

10. Are there chart notes or medical record documentation stating the patient's diagnosis of thalassemia (beta-thalassemia with or without alpha-globin [alpha-thalassemia] gene variants, hemoglobin E [HbE]/beta-thalassemia, or alpha-thalassemia/hemoglobin H [HbH] disease) was previously confirmed by appropriate testing (i.e., hemoglobin electrophoresis or high-performance liquid chromatography [HPLC], molecular genetic testing)? ACTION REQUIRED: If Yes, please attach supporting documentation.
ACTION REQUIRED: Submit supporting documentation
11. Does the patient have transfusion-dependent thalassemia?
12. Has the patient required at least 6 red blood cell (RBC) units to be transfused in the previous 24 weeks?
13. Prior to starting treatment with the requested drug, does the patient have symptomatic anemia?
14. Has the patient's pretreatment or pretransfusion hemoglobin (Hgb) level been drawn? ACTION REQUIRED: If Yes, please attach laboratory result or supporting chart note(s) of pretreatment or pretransfusion Hgb level.
ACTION REQUIRED: Submit supporting documentation
15. What is the patient's pretreatment or pretransfusion hemoglobin (Hgb) level?
Less than or equal to 11 g/dL (If checked, go to 16)
Greater than 11 g/dL (If checked, no further questions)
16. Is the patient 18 years of age or older? Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.