CAREFIRST COMMERCIAL - NON-RISK - FORMULARY 1 - SPC
Jesduvroq SGM

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at 866-249-6155. Please contact CVS Caremark at 866-814-5506 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Jesduvroq SGM.

Patient Information

Patient Name:
Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐
Patient ID:
Patient Group:
Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name
Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐
Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐
Physician Addr.:
City, St, Zip:

Drug Name (select from list of drugs shown)

Jesduvroq

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 patient's diagnosis?

   Anemia due to chronic kidney disease (CKD) (If checked, go to 2) ☐
   Other, please specify. (If checked, no further questions) _____

2. Will the requested medication be used concomitantly with erythropoiesis stimulating agents (ESAs)? **Y** ☐ **N** ☐
3. Has the patient received therapy with the requested medication in the previous month (within 30 days of request)? **Y** ☐ **N** ☐
4. Has the patient completed at least 12 weeks of therapy with the requested medication? Indicate therapy start date and number of weeks completed. **Y** ☐ **N** ☐
   _____
5. At any time since the patient started therapy with the requested medication, has the patient's hemoglobin (Hgb) level increased by 1 g/dL or more? **Y** ☐ **N** ☐
6. At any time since the patient started therapy with the requested medication, has the patient's hemoglobin (Hgb) level increased by 1 g/dL or more? **Y** ☐ **N** ☐
7. Has the patient been assessed for iron deficiency anemia? **Y** ☐ **N** ☐
8. What is the most recent serum transferrin saturation (TSAT) level? Indicate percentage.

   Less than 20% (If checked, go to 10) _____
   Greater than or equal to 20% (If checked, go to 9) _____

Unknown (If checked, go to 10) ☐

9. Was the most recent serum transferrin saturation (TSAT) level obtained within the prior 3 months? Indicate date lab was drawn. **Y** ☐ **N** ☐

_____

10. Is the patient receiving iron therapy? **Y** ☐ **N** ☐

11. What is the patient's current hemoglobin (Hgb) level (exclude values due to a recent transfusion)?

Less than 12 g/dL (If checked, go to 12) ☐

Greater than or equal to 12 g/dL (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

12. 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. **Y** ☐ **N** ☐

_____

13. Is the patient currently receiving dialysis? **Y** ☐ **N** ☐

14. Has the patient been assessed for iron deficiency anemia? **Y** ☐ **N** ☐

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

Less than 20% (If checked, go to 17) _____

Greater than or equal to 20% (If checked, go to 16) _____

Unknown (If checked, go to 17) ☐

16. Was the most recent serum transferrin saturation (TSAT) level obtained within the prior 3 months? Indicate date lab was drawn. **Y** ☐ **N** ☐

_____

17. Is the patient receiving iron therapy? **Y** ☐ **N** ☐

18. What is the patient's pretreatment hemoglobin (Hgb) level (exclude values due to a recent transfusion)?

Less than or equal to 11 g/dL (If checked, go to 19) ☐

Greater than 11 g/dL (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

19. 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 (If checked, go to 20) _____

No (If checked, no further questions) _____

Unknown (If checked, no further questions) ☐

20. Is the patient currently receiving dialysis? **Y** ☐ **N** ☐

21. How long has the patient been receiving dialysis?

Greater than or equal to 4 months (If checked, no further questions) ☐

Less than 4 months (If checked, no further questions) ☐

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.