CAREFIRST COMMERCIAL - NON-RISK - SPC

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 the medication.

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)

Mircera

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 other erythropoiesis stimulating agents (ESAs)? **Y** ☐ **N** ☐

3. Has the patient received erythropoiesis stimulating agent (ESA) therapy in the previous month (within 30 days of request)? **Y** ☐ **N** ☐

4. Has the patient completed at least 12 weeks of erythropoiesis stimulating agent (ESA) therapy? Indicate therapy start date and number of weeks completed. **Y** ☐ **N** ☐

   _____

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

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

   Less than 20% (If checked, go to 8) _____

   Greater than or equal to 20% (If checked, go to 7) _____

   Unknown (If checked, go to 8) ☐

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

   _____

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

9. At any time since the patient started ESA therapy, has the patient's hemoglobin (Hgb) increased by 1 g/dL or more? **Y** ☐ **N** ☐

10. 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 11) ☐
- Greater than or equal to 12 g/dL (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

11. 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 (If checked, no further questions) _____
- No (If checked, no further questions) _____
- Unknown (If checked, no further questions) ☐

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

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

- Less than 20% (If checked, go to 15) _____
- Greater than or equal to 20% (If checked, go to 14) _____
- Unknown (If checked, go to 15) ☐

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

_____

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

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

- Less than 10 g/dL (If checked, go to 17) ☐
- Greater than or equal to 10 g/dL (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

17. 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, no further questions) _____
- No (If checked, no further questions) _____
- Unknown (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