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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:** 4/20/2026
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 due to chronic kidney disease (CKD) (If checked, go to 2)
 - Other, please specify. (If checked, no further questions)
 - _____
2. Will the requested drug be used concomitantly with erythropoiesis stimulating agents (ESAs)? **Y** **N**
3. Has the patient been assessed for iron deficiency anemia? **Y** **N**
4. What is the most recent serum transferrin saturation (TSAT) level? Indicate as a percentage.
 - Less than 20% (If checked, go to 6)
 - _____
 - Greater than or equal to 20% (If checked, go to 5)
 - _____
 - Unknown (If checked, go to 6)
5. Was the most recent serum transferrin saturation (TSAT) level obtained within the prior 3 months? Indicate date lab was drawn. **Y** **N**
- _____
6. Is the patient receiving iron therapy? **Y** **N**
7. Is the patient 18 years of age or older? **Y** **N**
8. Is the request for continuation of therapy? **Y** **N**
9. Is the patient currently receiving dialysis? **Y** **N**
10. What is the patient's current hemoglobin (Hgb) level (exclude values due to a recent transfusion)? **ACTION REQUIRED:** If yes, attach chart notes, medical records, or laboratory results of current (within the last 30 days) hemoglobin level.
 - 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)

ACTION REQUIRED: Submit supporting documentation

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. Y N

12. 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 13)

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

Unknown (If checked, no further questions)

13. 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 14)

No (If checked, no further questions)

Unknown (If checked, no further questions)

14. Is the patient currently receiving dialysis? Y N

15. How long has the patient been receiving dialysis?

Greater than or equal to 3 months (If checked, no further questions)

Less than 3 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

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