



Epogen, Procrit, Retacrit Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

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 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. 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.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **Physician Office Fax:** _____
Physician Office Telephone: _____
Request Initiated For: _____

Please indicate patient's therapy status:

- New start or re-start of therapy: Please complete the following forms in entirety and fax to 866-249-6155.
 - Continuation of therapy: Please complete the following forms in 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.

1. Which drug is being prescribed? Epogen Procrit Retacrit Other _____
2. What is the patient's diagnosis or reason for requesting therapy?
 - Anemia in chronic kidney disease (CKD)
 - Anemia due to myelosuppressive chemotherapy
 - Anemia in myelodysplastic syndrome (MDS)
 - Presurgical use to reduce allogeneic blood transfusions
 - Anemia in CHF
 - Anemia in rheumatoid arthritis
 - Anemia due to hepatitis C treatment
 - Anemia due to zidovudine treatment in a patient with HIV infection
 - Anemia in patients whose religious beliefs forbid blood transfusions
 - Anemia in patients with primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis
 - Other _____
3. What is the ICD-10 code? _____
4. What is the patient's hemoglobin (Hgb) level? *Exclude values due to recent transfusion*
Pretreatment(i.e., within 30 days of request): Hgb: _____ g/dL Date of lab: _____
Current (i.e., within 30 days of request): Hgb: _____ g/dL Date of lab: _____

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5. Has the patient received erythropoiesis stimulating agent (ESA) therapy in the previous month (within 30 days of request)? Yes No *If No, skip to diagnosis section*
6. At any time since the patient started ESA therapy, has the patient's Hgb increased by 1 g/dL or more? *If Yes, skip to diagnosis section* Yes No
7. How many weeks of ESA therapy has the patient completed? _____ weeks;
Document start date: _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Anemia due to Myelosuppressive Chemotherapy

8. Does the patient have a diagnosis of a non-myeloid malignancy? Yes No
9. Is the intent of chemotherapy to cure the cancer (as opposed to palliative management or inducing remission)? Yes No

Section B: Anemia due to Zidovudine Treatment in a Patient with HIV Infection

10. Is the patient currently receiving treatment with zidovudine-containing medications? Yes No

Section C: Anemia due to Hepatitis C Treatment

11. Is the patient currently receiving treatment with ribavirin in combination with either interferon alfa or peginterferon alfa? Yes No

Section D: Presurgical Use to Reduce Allogeneic Blood Transfusions

12. Is the patient scheduled to have an elective, noncardiac, nonvascular surgery? Yes No

Section E: Anemia in Patients with Primary Myelofibrosis, Post-Polycythemia Vera Myelofibrosis, or Post-Essential Thrombocythemia Myelofibrosis-New Start ONLY

13. Does the patient have symptomatic anemia? Yes No
14. What is the patient's pretreatment serum erythropoietin level? _____ mU/mL Not available

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)

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