Mircera

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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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

Please indicate patient's therapy status:

- ❑ New start or re-start of therapy: Please complete the following form in its entirety and fax to 866-249-6155.
- ❑ Continuation of therapy: Please complete the following form in its 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. What is the diagnosis?
   - ❑ Anemia due to chronic kidney disease (CKD)
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. What is the patient's hemoglobin (Hgb) level? *(Exclude values due to recent transfusion)*
   Pretreatment(within 30 days of request):
   Hgb: _____ g/dL Date of lab: _____

   Current (within 30 days of request):
   Hgb: _____ g/dL Date of lab: _____ ❑ Not applicable (new to therapy)

4. Is this request for continuation of erythropoiesis stimulating agent (ESA) therapy (i.e., patient has received Mircera in previous two months or has received another ESA therapy in previous month)?
   ❑ Yes ❑ No *If No, no further questions*

5. Since the initiation of ESA therapy, has the patient ever responded to treatment with a rise of Hgb greater than or equal to 1g/dL compared to baseline? *If Yes, no further questions* ❑ Yes ❑ No

6. How many weeks of ESA therapy has the patient completed? _____ weeks;
   Document start date: _____

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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)**