

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples or is a restart of therapy, please choose "new start of therapy". new start of therapy continued therapy- start date:

(if CKD, hepatitis C, preoperative, zidovudine) Which of the following applies to your patient?

- patient's serum ferritin is 100 mcg/L or higher
- patient's serum transferrin saturation is 20% or higher
- neither of the above
- unknown

(if chemo, MDS, or MF) Which of the following applies to your patient?

- Patient's serum ferritin is 30 mcg/L or higher
- Patient's serum transferrin saturation is 20% or higher
- neither of the above
- unknown

(if neither/unknown to either of the 2 previous questions) Please provide current lab levels to support that your patient has adequate iron stores (transferrin, ferritin, and transferrin saturation), including dates of draws.

What is/was your patient's PRETREATMENT hemoglobin level (g/dL) [prior to use of epoetin (Aranesp, Epogen, Mircera, Procrit, Retacrit)]? _____

(if **chemotherapy, MDS or MF**, continued therapy) Please provide a hemoglobin level (g/dL) for your patient taken within the first 12 weeks of therapy with epoetin and include the date the lab was drawn.

(if **CKD or preoperative**, continued therapy) Please provide a recent hemoglobin level (g/dL) for your patient while on therapy with epoetin and include the date the lab was drawn.

(if **hepatitis C or zidovudine**, continued therapy) Please provide a hemoglobin level (g/dL) for your patient taken within the first 6 months of therapy with epoetin and include the date the lab was drawn.

(if **chemotherapy**) Is your patient being treated for either AML or CML (acute myeloid leukemia or chronic myeloid leukemia)?

Yes No

(if **chemotherapy**) Is your patient receiving palliative chemotherapy?

Yes No

(if **chemotherapy**) Is your patient currently receiving myelosuppressive chemotherapy treatments?

Yes No

(if yes) Is chemotherapy expected to continue for at least 2 more months (8 weeks)?

Yes No

How many more weeks of chemotherapy are planned? _____

(if **hepatitis C**) How many more weeks of hepatitis C therapy is your patient expected to receive? _____

(if **hepatitis C**) Is your patient currently receiving ribavirin in combination with either interferon alfa (Intron A) or peginterferon alfa (Pegasys, PegIntron)?

Yes No

(if **MDS or MF**) What is/was your patient's PRETREATMENT erythropoietin level [prior to use of epoetin (Aranesp, Epogen, Procrit, Retacrit)]? _____

(if **MDS or MF**, continued therapy) What is your patient's current hemoglobin level and date of lab draw? _____

(if **preoperative**, continued therapy) Please explain the clinical rationale for your patient to continue epoetin, including surgery date.

(if **preoperative**) Is anemia secondary to autologous blood donation (patient self-donated blood)?

Yes No

(if preoperative) Is your patient not willing or not able to donate autologous blood prior to surgery?

Yes No

(if **preoperative**) Is your patient scheduled for elective surgery?

Yes No

(if **preoperative**) Is your patient scheduled for cardiac or vascular surgery?

Yes No

(if no/unknown) What kind of surgery is your patient scheduled to undergo? _____

(if zidovudine) Is your patient currently receiving zidovudine (Retrovir) treatment?

Yes No

Additional Pertinent Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

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