Doptelet (avatrombopag)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Chronic liver disease undergoing a procedure ☐ Idiopathic thrombocytopenia(ITP) ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Is prescriber one of the below? □ **Yes** □ **No :**
□ **Hematologist/oncologist** □ **Gastroenteroloist** □ **Hepatologist**

<u>For patients with chronic liver disease AND undergoing a procedure:</u>

Is the patient going to have one of the below procedures? □ **Yes** □ **No** ***Please circle one.***

- paracentesis
- thoracentesis
- gastrointestinal endoscopy
- liver biopsy
- bronchoscopy
- ethanol ablation therapy
- chemoembolization
- vascular catheterization
- transjugular intrahepatic portosystemic shunt
- dental procedure
- renal biopsy
- biliary intervention
- nephrostomy tube placement
- radiofrequency ablation
- laparoscopic intervention

Is patient's chronic liver disease Model for End-stage liver disease(MELD) score <u>≤</u> 24? □ **Yes** □ **No**
Please submit chart documentation.

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Is patient's thrombocytopenia mean baseline platelet count less than 50,000? □ Yes □ No *Please submit chart documentation.*

<u>For patient's with idiopathic thrombocytopenia(ITP):</u>
For <u>INITIAL</u> Request of <u>immune (idiopathic) thrombocytopenic purpura (ITP),</u> answer the following:
Is Promacta prescribed by a hematology/oncology specialist? □ Yes □ No

Is the patient's platelet count less than 30,000/mcL OR greater than or equal to 30,000/mcL with additional risk factors for bleeding? □ Yes □ No **Please submit documentation.*

Please submit with chart notes the exact month and year that patient was diagnosed with immune (idiopathic) thrombocytopenic purpura (ITP) _____

For newly diagnosed primary ITP, is the request for Promacta(eltrombopag) within 3 months since the initial date of diagnosis? □ Yes □ No

For persistent primary ITP, is the request for Promacta(eltrombopag) 3 to 12 months since the initial date of diagnosis? □ Yes □ No

For chronic persistent relapsed primary ITP, is the request for Promacta(eltrombopag) greater than or equal to 12 months since the initial diagnosis? □ Yes □ No

Have all other causes of secondary ITP been ruled out such as: Inherited thrombocytopenia, Myelodysplastic Syndrome, HIV, HCV, CLL, drug-induced immune thrombocytopenia, SLE, RA, common variable immune deficiency (CVID), Helicobacter pylori infection, CMV, selective IgA deficiency, autoimmune lymphoproliferative syndrome (ALPS)? □ Yes □ No

Has the patient had an insufficient response, intolerance or or absolute contraindication to corticosteroids?* □ Yes □ No **Please submit documentation.*

Has the patient had an insufficient response, intolerance or or absolute contraindication to immunoglobulins (IVIG)?* □ Yes □ No **Please submit documentation.*

Has the patient had an insufficient response, intolerance or absolute contraindication to rituximab?* □ Yes □ No **Please submit documentation.*

Has the patient had a splenectomy with an inadequate response? □ Yes □ No
If "no" to the above question, does the patient have an absolute contraindication to splenectomy?*□ Yes □ No **Please submit documentation which includes surgeon or anesthesiologist consultation.*
If "yes" to the above question, has the patient had an insufficient response or intolerance to post-splenectomy
corticosteroids?* □ Yes □ No **Please submit documentation.*

For patients over 61 years of age, do the results from the most recent bone marrow aspiration show evidence of myelodysplasia as a possible cause for thrombocytopenia?* □ Yes □ No **Please submit documentation.*

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For RENEWAL Request of immune (idiopathic) thrombocytopenic purpura (ITP):
Is patient continuing to have a positive clinical response? □ Yes □ No *Please submit documentation.*

Has the patient had a splenectomy with an inadequate response? □ Yes □ No
If "no" to the above question, does the patient have an absolute contraindication to splenectomy?*□ Yes □ No *Please submit documentation which includes surgeon or anesthesiologist consultation.*

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or 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 or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909