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

MEMBER'S LAST NAME:	ME	MBER'S FIRST NA	AME:			
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.						
			☐ URGEN			
MEMBER INFORMATION	N	EIDOT MANE				
LAST NAME:		FIRST NAME:				
PHONE NUMBER:		DATE OF BIRTH:				
STREET ADDRESS:						
CITY:		STATE:	ZIP CODE:			
PATIENT INSURANCE II	NUMBER:					
MALE FEMALE	HEIGHT (IN/CM): W	/EIGHT (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 INFORMA	TION					
LAST NAME:		FIRST NAME:				
PRESCRIBER SPECIAL	ΓY:	EMAIL ADDRESS:				
NPI NUMBER:		DEA NUMBER:				
PHONE NUMBER:		FAX NUMBER:				
STREET ADDRESS:						
CITY:		STATE:	ZIP CODE:			
REQUESTER (if different than prescriber):		OFFICE CONTAC	CT PERSON:			
	CAL DISPENSING INFORMA	ATION				
MEDICATION NAME:						
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILL	QUANTITY: LS:			
☐ NEW THERAPY		NEWAL: DATE THE				
DURATION OF THERAP	Y (SPECIFIC DATES):					

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MEMBER'S L	AST NAME:	MEMBER'S FIRST N	NAME:		
Continued on r	next page				
	PATIENT TRIED ANY s, complete below)	OTHER MEDICATIONS FOR THIS NO	CONDITION?		
MEDICATION		DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAG	NOSES:		ICD-10:		
	rer disease undergoing thrombocytopenia(ITP				
Other diag	nosis:	ICD-10 Code(s):			
	CLINICAL INFORMATA PRIOR AUTHORIZ	ATION: PLEASE PROVIDE ALL REI ZATION.	EVANT CLINICAL INFORMATION		
Is patient go	ing to be using drug	in combination with a clinical trial	? 🗌 Yes 🔲 No		
Is prescriber one of the below? Yes No: Hematologist/oncologist Gastroenteroloist Hepatologist Will patient use in combination with Promacta(eltrombopag), Nplate(romiplostim), Tavalisse(fostamatinib), and/or Wayrilz(rilzabrutinib)? Yes No					
For patients	with chronic liver als	ease AND undergoing a procedure	<u>e:</u>		
0	paracentesis thoracentesis gastrointestinal endo liver biopsy bronchoscopy ethanol ablation thera chemoembolization vascular catheterizati transjugular intrahepa dental procedure renal biopsy biliary intervention nephrostomy tube pla	apy ion atic portosystemic shunt acement	No Please circle one.		
0	radiofrequency ablati laparoscopic interver				

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MEMBER'S LAST NAME: MEMBER'S FIRST NAME:	
Is patient's chronic liver disease Model for End-stage liver disease(MELD) score ≤ 24? □ Yes □ No Please submit chart documentation.	
Is patient's thrombocytopenia mean baseline platelet count less than 50,000? \Box Yes \Box No <i>Please submit chart documentation.</i>	
For patient's with idiopathic thrombocytopenia(ITP): For INITIAL Request of immune (idiopathic) thrombocytopenic purpura (ITP), 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? \square Yes \square 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? \hdots Yes \hdots No	
For persistent primary ITP, is the request for Promacta(eltrombopag) 3 to 12 months since the initial date of diagnosis? \Box Yes \Box No	
For chronic persistent relapsed primary ITP, is the request for Promacta(eltrombopag) greater than or equal to 12 months since the initial diagnosis? \Box Yes \Box 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.	

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	o the results from the most recent bone marrow aspiration show ssible cause for thrombocytopenia?* □ Yes □ No *Please submit		
	(idiopathic) thrombocytopenic purpura (ITP): tive clinical response? □ Yes □ No * <i>Pl</i> ease submit documentation	n.	
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, diag information the physician feels is in	noses, symptoms, medications tried or failed, and/or any other portant to this review?		
Please note: Not all drugs/diagnosis a required information is received.	are covered on all plans. This request may be denied unless all		
understand that the Health Plan, insure	on provided is true and accurate to the best of my knowledge. I er, Medical Group or its designees may perform a routine audit and sary to verify the accuracy of the information reported on this form.		
Prescriber Signature or Electronic I.	D. Verification: Date:	_	
information that is legally privileged. If disclosure, copying, distribution, or act	cuments accompanying this transmission contain confidential health you are not the intended recipient, you are hereby notified that any ion taken in reliance on the contents of these documents is strictly formation in error, please notify the sender immediately (via return truction of these documents.		

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

