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

MEMBER'S LAST NAME: M		EMBER'S FIRST NAME:		
that is important for the rev	ut all applicable sections com view (e.g., chart notes or lab o rotected Health Information u	data, to support the authoriz	any additional documentation zation request). Information	
			☐ URGENT	
MEMBER INFORMATIO	N			
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:				
CITY:		STATE: ZIP CODE:		
PATIENT INSURANCE I	D NUMBER:			
MALE FEMALE	HEIGHT (IN/CM): W	/EIGHT (LB/KG):	ALLERGIES:	
FOLLOWING LINK: PRIM PATIENT'S AUTHORIZED AUTHORIZED REPRESE	ZATION FORM WITH THIS F IETHERAPEUTICS.COM/NO D REPRESENTATIVE (IF AP NTATIVE'S PHONE NUMBE	PPLICABLE):		
PRESCRIBER INFORMA	ATION	EIDOT MANE		
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 PER	SON:	
MEDICATION OF MEDI		ATION .		
MEDICATION OR MEDIC MEDICATION NAME:	CAL DISPENSING INFORMA	ATION		
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
☐ NEW THERAPY		NEWAL: DATE THERAPY	INITIATED:	
DURATION OF THERAP	Y (SPECIFIC DATES):			

©2017-2024 Prime Therapeutics Management LLC, a Prime Therapeutics company Prime Therapeutics Management – Commercial Clients. Revision Date: 11.15.2025



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

MEMBER'S LAST N	AME:	MEMBER'S FIR	RST NAME:
Continued on next pa	age		
	NT TRIED ANY OTHER	MEDICATIONS FOR	THIS CONDITION?
	plete below) NO		
MEDICATION/THE (SPECIFY DRUG N DOSAGE):	_	FY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSE	S:		ICD-10:
	ease undergoing a proce	dure	
Other diagnosis:		ICD-10 Code	e(s):
	NICAL INFORMATION: F		L RELEVANT CLINICAL INFORMATION
	be using drug in comb		l trial? ☐ Yes ☐ No
□ Hematologist/on Will patient use in	of the below? □ Yes □ N cologist □ Gastroenter combination with Prom /or Wayrilz(rilzabrutinib	oloist □ Hepatologist nacta(eltrombopag), N	st Nplate(romiplostim), Tavalisse(
Is patient age 1 ye	ear to 17 years, inclusiv	e? ☐ Yes ☐ No	
Yes	of age or older, AND has provide documentations:	n.	ing or has an enteral feeding tube?
1 Of patients with t	monic liver disease Alv	to undergoing a proc	Jedui e.
o para o thora o gastr o liver o brond o ethal	g to have one of the belocentesis acentesis rointestinal endoscopy biopsy choscopy ablation therapy noembolization	ow procedures? □ Y	'es □ No Please circle one.

©2017-2024 Prime Therapeutics Management LLC, a Prime Therapeutics company Prime Therapeutics Management – Commercial Clients. Revision Date: 11.15.2025



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

NEMBER'S LAST NAME: MEMBER'S FIRST NAME:	
 biliary intervention 	
o nephrostomy tube placement	
o radiofrequency ablation	
o laparoscopic intervention	
Is patient's chronic liver disease Model for End-stage liver disease(MELD) score \leq 24? \Box Yes \Box 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? \Box Yes \Box 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? \Box Yes \Box 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 * <i>Please submit documentation.</i>	+
Has the patient had a splenectomy with an inadequate response? □ Yes □ No	



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

MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:
Yes □ No *Please submit documentation If "yes" to the above question, has the splenectomy	e patient have an absolute contraindication to splenectomy?* ion which includes surgeon or anesthesiologist consultation. e patient had an insufficient response or intolerance to post-
corticosteroids?* □ Yes □ No <i>*Please</i> s	submit documentation.
	the results from the most recent bone marrow aspiration show sible cause for thrombocytopenia?* □ Yes □ No *Please submit
	liopathic) thrombocytopenic purpura (ITP): e clinical response? □ Yes □ No * <i>Please submit documentation</i>
If "no" to the above question, does the	th an inadequate response? □ Yes □ No e patient have an absolute contraindication to splenectomy?*□ ion which includes surgeon or anesthesiologist consultation.
Are there any other comments, diagnostinformation the physician feels is impos-	oses, symptoms, medications tried or failed, and/or any other ortant to this review?
Please note: Not all drugs/diagnosis are required information is received.	e covered on all plans. This request may be denied unless all
understand that the Health Plan, insurer,	provided is true and accurate to the best of my knowledge. I Medical Group or its designees may perform a routine audit and try to verify the accuracy of the information reported on this form.
Prescriber Signature or Electronic I.D.	. Verification: Date:
	ments accompanying this transmission contain confidential health ou are not the intended recipient, you are hereby notified that any

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

©2017-2024 Prime Therapeutics Management LLC, a Prime Therapeutics company Prime Therapeutics Management – Commercial Clients. Revision Date: 11.15.2025





«Brand_Name» («Generic_Name») **Prior Authorization Request Form**

Caterpillar Prescription Drug Benefit

«PA_form_»