Nplate

CareFirst Prior Authorization Request

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Nplate SGM 1927-A - 01/2025.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. Will the requested drug be used concurrently with other thrombopoietin receptor agonists (e.g., Promacta, Alvaiz, Doptelet, Mulpleta) or with spleen tyrosine kinase inhibitors (e.g., Tavalisse)?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the diagnosis?

❒ Immune thrombocytopenia (ITP), *Continue to 3*
❒ Hematopoietic syndrome of acute radiation syndrome (acute exposure to myelosuppressive doses of radiation), *Continue to 13*

❒ Myelodysplastic syndromes, *Continue to 14*

❒ Chemotherapy-induced thrombocytopenia (CIT), *Continue to 18*

❒ Other, please specify: _____, *No further questions*

3. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Is the request for continuation of therapy with Nplate?
❒ Yes, *Continue to 5*
❒ No, *Continue to 6*

5. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 6*

❒ No, *Continue to 9*

❒ Unknown, *Continue to 6*

6. Has the patient had an inadequate response or is intolerant to prior therapy with corticosteroids, immunoglobulins, or splenectomy?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. What is/was the lowest untransfused platelet count at any point prior to the initiation of the requested drug? ***ACTION REQUIRED***: Attach laboratory documentation or chart notes with untransfused platelet count prior to the initiation of immune thrombocytopenia (ITP) therapy.
❒ Less than 30,000/mcL (30x10^9/L) ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ 30,000/mcL to 50,000/mcL (30x10^9/L to 50x10^9/L) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ Greater than 50,000/mcL (50x10^9/L), *Continue to 8*

❒ Unknown, *Continue to 8*

8. Does the patient have symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma) or risk factors for bleeding? Examples of risk factors (not all inclusive): a) Undergoing a medical or dental procedure where blood loss is anticipated, b) Comorbidities for bleeding (e.g., peptic ulcer disease), c) Mandated anticoagulation therapy, d) Profession (e.g., construction worker) or lifestyle (e.g., plays contact sports) that predisposes the patient to trauma.

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

9. What is the patient's current platelet count? ***ACTION REQUIRED***: Attach laboratory documentation or chart notes with current platelet count.

❒ Less than 50,000/mcL (50x10^9/L) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 10*
❒ 50,000/mcL to 200,000/mcL (50x10^9/L to 200x10^9/L) ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Greater than 200,000/mcL (200x10^9/L) to less than or equal to 400,000/mcL (400x10^9/L) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*
❒ Greater than 400,000/mcL (400x10^9/L), *No further questions*
❒ Unknown, *No further questions*

10. Is the platelet count sufficient to prevent clinically important bleeding?
❒ Yes, *No Further Questions*
❒ No, *Continue to 11*

11. Has the patient received a maximal dose of the requested drug for at least 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. Will dosing be adjusted to achieve a platelet count sufficient to avoid clinically important bleeding?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

13. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

14. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Is the request for continuation of therapy with Nplate?
❒ Yes, *Continue to 16*
❒ No, *No Further Questions*

16. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *No further questions*
❒ No, *Continue to 17*
❒ Unknown, *No further questions*

17. Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

18. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is the request for continuation of therapy with Nplate?
❒ Yes, *Continue to 20*
❒ No, *Continue to 24*

20. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 24*

❒ No, *Continue to 21*

❒ Unknown, *Continue to 24*

21. Is the requested drug being used to maintain dose schedule and intensity of chemotherapy?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. What is the patient's current platelet count? ***ACTION REQUIRED***: Attach laboratory documentation or chart notes with current platelet count.

❒ Less than 100,000/mcL (100x10^9/L), *No further questions*
❒ Greater than or equal to 100,000/mcL (100x10^9/L) to less than or equal to 200,000/mcL (200x10^9/L) ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Greater than 200,000/mcL (200x10^9/L), *No further questions*

❒ Unknown, *No further questions*

24. Has chemotherapy administration been delayed related to thrombocytopenia?
❒ Yes, *No Further Questions*
❒ No, *Continue to 25*

25. What is the patient's platelet count? ***ACTION REQUIRED***: Attach laboratory documentation or chart notes with platelet count prior to the initiation of CIT treatment.

❒ Less than 100,000/mcL (100x10^9/L) Note: Submit supporting documentation, *Continue to 26*

❒ Greater than or equal to 100,000/mcL (100x10^9/L), *Continue to 26*

❒ Unknown, *Continue to 26*

26. Has the patient's platelet count remained less than 100,000/mcL (100x10^9/L) for at least 3 to 4 weeks following the last chemotherapy administration?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720