PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 8/12/2024
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. Will the requested drug be used concurrently with other thrombopoietin receptor agonists (e.g., Nplate, Doptelet, Mulpleta) or with spleen tyrosine kinase inhibitors (e.g., Tavalisse)? **Y** ☐ **N** ☐

2. What is the prescribed product?
   - Promacta (If checked, go to 3) ☐
   - Alvaiz (If checked, go to 4) ☐

3. What is the diagnosis?
   - Persistent or chronic immune thrombocytopenia (ITP) (If checked, go to 5) ☐
   - Thrombocytopenia associated with chronic hepatitis C (If checked, go to 15) ☐
   - Aplastic anemia (If checked, go to 20) ☐
   - Myelodysplastic syndromes (If checked, go to 32) ☐
   - MYH9-related disease with thrombocytopenia (If checked, go to 36) ☐
   - Chemotherapy-induced thrombocytopenia (CIT) (If checked, go to 37) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

4. What is the diagnosis?
   - Persistent or chronic immune thrombocytopenia (ITP) (If checked, go to 5) ☐
   - Thrombocytopenia associated with chronic hepatitis C (If checked, go to 15) ☐
   - Aplastic anemia (If checked, go to 20) ☐
   - Chemotherapy-induced thrombocytopenia (CIT) (If checked, go to 37) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

5. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist? **Y** ☐ **N** ☐

6. Is the request for continuation of therapy with Promacta or Alvaiz? **Y** ☐ **N** ☐

7. Is the patient currently receiving Promacta or Alvaiz through samples or a manufacturer's patient assistance program?

- Yes (If checked, go to 8) ☐
- No (If checked, go to 11) ☐
- Unknown (If checked, go to 8) ☐

8. Has the patient had an inadequate response or intolerance to corticosteroids, immunoglobulins, or splenectomy? **Y** ☐ **N** ☐

9. What is/was the lowest untransfused platelet count at any point prior to the initiation of Promacta or Alvaiz? 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) (If checked, no further questions) ☐
- 30,000/mcL to 50,000/mcL (30x10^9/L to 50x10^9/L) (If checked, go to 10) ☐
- Greater than 50,000/mcL (50x10^9/L) (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐
- ACTION REQUIRED: Submit supporting documentation

10. 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) Comorbidity (e.g., peptic ulcer disease, hypertension), c) Mandated anticoagulation therapy, d) Profession (e.g., construction worker) or lifestyle (e.g., plays contact sports) that predisposes patient to trauma. **Y** ☐ **N** ☐

11. 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) (If checked, go to 12) ☐
- 50,000/mcL to 200,000/mcL (50x10^9/L to 200x10^9/L) (If checked, no further questions) ☐
- Greater than 200,000/mcL (200x10^9/L) to less than or equal to 400,000/mcL (400x10^9/L) (If checked, go to 14) ☐
- Greater than 400,000/mcL (400x10^9/L) (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐
- ACTION REQUIRED: Submit supporting documentation

12. Is the platelet count sufficient to prevent clinically important bleeding? **Y** ☐ **N** ☐

13. Has the patient received a maximal dose of the requested drug for at least 4 weeks? **Y** ☐ **N** ☐

14. Will dosing be adjusted to achieve a platelet count sufficient to avoid clinically important bleeding? **Y** ☐ **N** ☐

15. Will the requested drug be prescribed by or in consultation with a prescriber specializing in one of the following: A) infectious disease, B) gastroenterology, C) hepatology, or D) transplant? **Y** ☐ **N** ☐

16. Is the request for continuation of therapy with Promacta or Alvaiz? **Y** ☐ **N** ☐

17. Is the patient currently receiving Promacta or Alvaiz through samples or a manufacturer's patient assistance program?

- Yes (If checked, go to 18) ☐
- No (If checked, go to 19) ☐
- Unknown (If checked, go to 18) ☐

18. Will Promacta or Alvaiz be used to initiate and maintain interferon-based therapy? **Y** ☐ **N** ☐

19. Is the patient still receiving interferon-based therapy? Y ☐ N ☐

20. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist? Y ☐ N ☐

21. Is the request for continuation of therapy with Promacta or Alvaiz? Y ☐ N ☐

22. Is the patient currently receiving Promacta or Alvaiz through samples or a manufacturer's patient assistance program?

- ☐ Yes (If checked, go to 23)
- ☐ No (If checked, go to 27)
- ☐ Unknown (If checked, go to 23)

23. What is the prescribed product?

- ☐ Promacta (If checked, go to 24)
- ☐ Alvaiz (If checked, go to 26)

24. Will Promacta be used as first-line treatment of severe aplastic anemia? Y ☐ N ☐

25. Will Promacta be used in combination with standard immunosuppressive therapy (e.g., horse antithymocyte globulin [h-ATG] and cyclosporine)? Y ☐ N ☐

26. Has the patient had an insufficient response to immunosuppressive therapy? Y ☐ N ☐

27. 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) (If checked, go to 28)
- ☐ 50,000/mcL to 200,000/mcL (50x10^9/L to 200x10^9/L) (If checked, no further questions)
- ☐ Greater than 200,000/mcL (200x10^9/L) to less than or equal to 400,000/mcL (400x10^9/L) (If checked, go to 31)
- ☐ Greater than 400,000/mcL (400x10^9/L) (If checked, no further questions)
- ☐ Unknown (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

28. Is the patient transfusion-independent? Y ☐ N ☐

29. Has the patient received appropriately titrated therapy for at least 16 weeks? Y ☐ N ☐

30. How many weeks of therapy has the patient received? (If less than 16 weeks received, please provide how many weeks of therapy the patient has received.)

- ☐ Less than 16 weeks (If checked, no further questions)

_____

- ☐ 16 weeks or more (If checked, no further questions)

31. Will dosing be adjusted to achieve and maintain an appropriate target platelet count? Y ☐ N ☐

32. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist? Y ☐ N ☐

33. Is the request for continuation of therapy with Promacta? Y ☐ N ☐

34. Is the patient currently receiving Promacta through samples or a manufacturer's patient assistance program?

- ☐ Yes (If checked, no further questions)
- ☐ No (If checked, go to 35)

Unknown (If checked, no further questions) ☐

35. Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)? **Y** ☐ **N** ☐

36. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist? **Y** ☐ **N** ☐

37. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist? **Y** ☐ **N** ☐

38. Is the request for continuation of therapy with Promacta or Alvaiz? **Y** ☐ **N** ☐

39. Is the patient currently receiving Promacta or Alvaiz through samples or a manufacturer's patient assistance program?

Yes (If checked, go to 40) ☐

No (If checked, go to 42) ☐

Unknown (If checked, go to 40) ☐

40. Does the patient have prolonged thrombocytopenia? **Y** ☐ **N** ☐

41. Is the patient post-allogenic transplant and has poor graft function? **Y** ☐ **N** ☐

42. Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date