

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



{{PANUMCODE}}

Doptelet

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 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at 1-866-814-5506. 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.

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Patient's Name: {{MEMFIRST}} {{MEMLAST}} Date: {{TODAY}}
Patient's ID: {{MEMBERID}} Patient's Date of Birth: {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} Physician Office Fax: {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
☐ Chronic immune thrombocytopenia (ITP)
☐ Thrombocytopenia in chronic liver disease
☐ Other _____
2. What is the ICD-10 code? _____
3. Is the requested drug prescribed by or in consultation with a hematologist, hepatologist, or gastroenterologist?
Indicate all that apply.
☐ Yes - hematologist
☐ Yes - hepatologist
☐ Yes - gastroenterologist
☐ No - none of the above
4. Will the requested drug be used concurrently with other thrombopoietin receptor agonists (e.g., Mupleta, Promacta, Nplate) or with spleen tyrosine kinase inhibitors (e.g., Tavalisse)? ☐ Yes ☐ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Chronic Immune Thrombocytopenia (ITP)

5. Is this a request for continuation of therapy with the requested drug? ☐ Yes ☐ No *If No, skip to #10*
6. What is the patient's current platelet count? **ACTION REQUIRED: Attach laboratory documentation or chart notes with current platelet count.** _____/mcL or $10^9/L$ (circle one) ☐ Unknown
If 50,000 to 200,000/mcL (50×10^9 to $200 \times 10^9/L$), no further questions.
If greater than 200,000/mcL (greater than $200 \times 10^9/L$) to less than or equal to 400,000/mcL ($400 \times 10^9/L$), skip to #9
7. Is the platelet count sufficient to prevent clinically important bleeding?
If Yes, no further questions. ☐ Yes ☐ No
8. Has the patient received a maximal dose of the requested drug for at least 4 weeks?
☐ Yes ☐ No *No further questions.*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Doptelet SGM - 1/2023.

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9. Will dosing be adjusted to achieve a platelet count sufficient to avoid clinically important bleeding?
☐ Yes ☐ No *No further questions.*
10. Has the patient had an inadequate response or is intolerant to prior therapy for chronic immune thrombocytopenia (for example, corticosteroids or immunoglobulins)? ☐ Yes ☐ No
11. What is/was the lowest untransfused platelet count prior to the initiation of any ITP therapy?
ACTION REQUIRED: Attach laboratory documentation or chart notes with untransfused platelet count prior to the initiation of ITP therapy. _____/mL or $10^9/L$ (circle one) ☐ Unknown
If less than 30,000/mL (less than $30 \times 10^9/L$), no further questions.
12. Does the patient have symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma) or risk factors for bleeding? ☐ Yes ☐ No
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 or hypertension)
c) Mandated anticoagulation therapy
d) Profession (e.g., construction worker) or lifestyle (e.g., plays contact sports) that predisposes patient to trauma

Section B: Thrombocytopenia in Chronic Liver Disease

13. Is this a request for continuation of therapy with the requested drug? ☐ Yes ☐ No *If No, skip to #15*
14. Has the patient been scheduled to undergo a new procedure since the last prior authorization approval?
☐ Yes ☐ No
15. What is the patient's untransfused platelet count (taken within 14 days of the request)?
ACTION REQUIRED: Attach laboratory documentation or chart notes with platelet count taken within 14 days of the request. _____/mL or $10^9/L$ (circle one) ☐ Unknown
16. Is the patient scheduled to undergo a procedure? ☐ Yes ☐ No

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)

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