



## Mulpleta

### 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.

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](mailto: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: \_\_\_\_\_ NPI#: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Physician Office Telephone: \_\_\_\_\_ Physician Office Fax: \_\_\_\_\_  
Request Initiated For: \_\_\_\_\_

1. What is the diagnosis?  
☐ Thrombocytopenia in chronic liver disease  
☐ Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. *If the product being requested for the treatment of thrombocytopenia in patients with Chronic Liver Disease (CLD), the preferred product for your patient's health plan is Doptelet. Can the patient's treatment be switched to a preferred product? **If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: [www.covermymeds.com/epa/caremark/](http://www.covermymeds.com/epa/caremark/) or call 1-866-452-5017.***  
☐ Yes - Doptelet ☐ No - Continue request for non-preferred product  
☐ N/A - Request is not for the treatment of thrombocytopenia in chronic liver disease
4. Does the patient have a documented inadequate response or intolerable adverse event to treatment with the preferred product (Doptelet)? **ACTION REQUIRED: If Yes, attach supporting chart notes(s).** ☐ Yes ☐ No
5. Is the requested drug prescribed by or in consultation with a hematologist, hepatologist or gastroenterologist?  
☐ Yes ☐ No
6. Is this a request for continuation of therapy with the requested drug? ☐ Yes ☐ No *If No, skip to #8*
7. Has the patient been scheduled to undergo a new procedure since the last prior authorization approval?  
☐ Yes ☐ No
8. 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.** \_\_\_\_\_ /mcL or x10<sup>9</sup>/L (*circle one*) ☐ Unknown
9. Is the patient scheduled to undergo a procedure? ☐ Yes ☐ No

**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. Mulpleta VF, ACSF SGM - 1/2023.

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10. Will the requested drug be used in combination with other thrombopoietin receptor agonists (e.g., Doptelet, Promacta, Nplate) or with spleen tyrosine kinase inhibitors (e.g., Tavalisse)? ☐ 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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