Nplate, Promacta (for Maryland only)

Prior Authorization Request

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

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 **1-866-814-5506.** 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. 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:** _____

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

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

1. What drug is being prescribed? ❑ Nplate ❑ Promacta ❑ Other _____

2. What is the diagnosis?
   ❑ Cyclic thrombocytopenia
   ❑ Chronic or persistent primary immune thrombocytopenia (ITP)
   ❑ Severe aplastic anemia
   ❑ Thrombocytopenia associated with chronic hepatitis C
   ❑ MYH9-related disease with thrombocytopenia
   ❑ Other _____

3. What is the ICD-10 code? _____

4. Would the prescriber like to request an override of the step therapy requirement?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*

5. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ACTION REQUIRED: ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***

6. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to diagnosis section and complete this form in its entirety.*

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

Section A: Chronic or Persistent Primary Immune Thrombocytopenia (ITP)

7. Has the patient received prescribed agent indicated above within the previous 120 days in a paid claim through a pharmacy or medical benefit? *If Yes, skip to #11* ❑ Yes ❑ No

8. Has the patient tried and had an inadequate response or is intolerant to corticosteroids, immunoglobulins, or splenectomy? ❑ Yes ❑ No

9. What is/was the untransfused platelet count at the time of diagnosis?
Indicate pre-treatment results: _____ /mcL or $x10^9$/L ***(circle one)***
If less than 30,000/mcL (less than $30x10^9$/L), no further questions

10. Does the patient have symptomatic bleeding (eg, significant mucous membrane bleeding, gastrointestinal bleeding or trauma) or risk factors for bleeding? ❑ Yes ❑ No *No further questions*
Examples of risk factors (not all inclusive):
    - Undergoing a medical or dental procedure where blood loss is anticipated
    - Comorbidity (eg, peptic ulcer disease or hypertension)
    - Mandated anticoagulation therapy
    - Profession (e.g., construction worker) or lifestyle (e.g., plays contact sports) predisposes the patient to trauma

11. What is the current platelet count?
Indicate current results: _____ /mcL or $x10^9$/L ***(circle one)***
If greater than or equal to 50,000/mcL to less than 200,000/mcL ($50x10^9$ to $200x10^9$/L), no further question.

12. *If less than 50,000/mcL ($50x10^9$/L),* is the platelet count sufficient to prevent clinically important bleeding?
If Yes, no further questions ❑ Yes ❑ No ❑ Not applicable, *skip to #14*

13. Has the patient received a maximal dose for at least 4 weeks? ❑ Yes ❑ No *No further questions*

14. *If greater than 200,000/mcL ($200x10^9$/L),* will the dose be adjusted down to a platelet count sufficient to avoid clinically important bleeding? ❑ Yes ❑ No

Section B: Thrombocytopenia Associated with Chronic Hepatitis C (Promacta Only)

15. Has the patient received a supply of Promacta within the previous 120 days in a paid claim through a pharmacy or medical benefit? ❑ Yes ❑ No *If No, skip to #17*

16. Is the patient still receiving interferon-based therapy? ❑ Yes ❑ No *No further questions*

17. Will Promacta be used to initiate and maintain interferon-based therapy? ❑ Yes ❑ No

18. What is/was the untransfused platelet count at the time of diagnosis?
Indicate pre-treatment results: _____ /mcL or $x10^9$/L ***(circle one)***

Section C: Severe Aplastic Anemia (Promacta Only)

19. Has the patient received a supply of Promacta within the previous 120 days in a paid claim through a pharmacy or medical benefit? *If Yes, skip to #22* ❑ Yes ❑ No

20. Has the patient tried and had an inadequate response to immunosuppressive therapy? ❑ Yes ❑ No

21. What is/was the untransfused platelet count at the time of diagnosis?
Indicate pre-treatment results: _____ /mcL or $x10^9$/L ***(circle one)*** *No further questions*

22. What is the current platelet count?
Indicate current results: _____ /mcL or $x10^9$/L ***(circle one)***
If greater than between 50,000 to less than or equal to 200,000/mcL ($50x10^9$ to $200x10^9$/L), no further questions

23. *If less than 50,000/mcL ($50x10^9$/L),* is the patient transfusion-independent?
If Yes, no further questions ❑ Yes ❑ No

24. Has the patient received appropriately titrated therapy for at least 16 weeks?
    ❑ Yes ❑ No ❑ Not applicable

25. *If greater than 200,000/mcL ($200x10^9/L$),* will dosing be reduced to achieve and maintain an appropriate target platelet count? ❑ 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)**