Nplate

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*

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

Criteria Questions:

1. What is the diagnosis?
   - ❑ Immune thrombocytopenia (ITP)
   - ❑ Myelodysplastic syndrome
   - ❑ Severe thrombocytopenia post cancer chemotherapy
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Will the requested drug be used concurrently with other thrombopoietin receptor agonists (e.g., Promacta, Doptelet, Mulpleta) or with spleen tyrosine kinase inhibitors (e.g., Tavalisse)? ❑ Yes ❑ No

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

Section A: Immune Thrombocytopenia (ITP)

4. Is the request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #6*

5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If No, skip to #9*

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

7. What is/was the lowest untransfused platelet count at any point prior to the initiation of the requested medication? ***ACTION REQUIRED: Attach laboratory documentation or chart notes with untransfused platelet count prior to the initiation of ITP therapy.***
   Indicate pre-treatment results: _____ /mcL or $x10^9$/L ***(circle one)*** ❑ Unknown
   If less than 30,000/mcL (less than $30x10^9$/L), no further questions.

8. Does the patient have symptomatic bleeding (e.g., 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 (e.g., 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

9. What is the patient's current platelet count? ***ACTION REQUIRED: Attach laboratory documentation or chart notes with current platelet count.***
   Indicate current results: _____ /mcL or $x10^9$/L ***(circle one)*** ❑ Unknown
   If greater than or equal to 50,000 to less than or equal to 200,000/mcL ($50x10^9$ to $200x10^9$/L), no further questions.

10. *If greater than 200,000/mcL (greater than $200x10^9$/L) to less than or equal to 400,000/mcL (less than or equal to $400x10^9$/L),* will dosing be reduced to obtain a platelet count sufficient to avoid clinically important bleeding? ❑ Yes ❑ No *No further questions*

11. *If less than 50,000/mcL (less than $50x10^9$/L),* is the platelet count sufficient to prevent clinically important bleeding? *If Yes, no further questions.* ❑ Yes ❑ No

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

Section B: Myelodysplastic Syndrome

13. Is the request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #15*

14. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If No, skip to #17*

15. Does the patient have lower risk disease, defined as Revised International Prognostic Scoring System (IPSS-R) (Very Low, Low, Intermediate), International Prognostic Scoring System (IPSS) (Low/Intermediate-1), WHO classification-based Prognostic Scoring System (WPSS) (Very Low, Low, Intermediate)? ❑ Yes ❑ No

16. Does the patient have severe or refractory thrombocytopenia following disease progression or no response to hypomethylating agents (such as azacitidine and decitabine) or immunosuppressive therapy?
❑ Yes ❑ No *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

Section C: Severe Thrombocytopenia Post Cancer Chemotherapy

18. Is the request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #21*

19. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If Yes or Unknown, skip to #21*

20. Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)? ❑ Yes ❑ No

21. What is the current platelet count? ***ACTION REQUIRED: Attach laboratory documentation or chart notes with current platelet count.***
Indicate current results: _____ /mcL or $x10^9$/L ***(circle one)*** ❑ Unknown

Step Therapy Override: Complete if Applicable.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	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)**

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