PRIOR AUTHORIZATION REQUEST
Doptelet

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Thrombocytopenia in patients with chronic liver disease – **Please answer questions 2 & 3**
   - ☐ Chronic immune thrombocytopenia – **Please answer questions 4 - 11**
   - ☐ All other indications or diagnoses – Please specify _____
2. ☐ Yes ☐ No Does the patient have a current platelet count of less than 50 x 10(9)/L (less than 50,000 per microliter)?
3. ☐ Yes ☐ No Is the patient scheduled to undergo a procedure within 10 to 13 days after starting Doptelet therapy?
4. Is the request for initial therapy or continuation of therapy?
   - ☐ Initial therapy
   - ☐ Continuation of therapy
5. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a hematologist?
6. ☐ Yes ☐ No Has the patient tried one other therapy?
7. ☐ Yes ☐ No Has the patient undergone splenectomy?
8. ☐ Yes ☐ No Does the patient have platelet count of less than 30 x 10^9/L (less than 30,000/microliter)?
9. ☐ Yes ☐ No Does the patient have a platelet count of less than 50 x 10^9/L (less than 50,000/microliter) and is at an increased risk of bleeding, according to the prescriber?
10. ☐ Yes ☐ No Has the patient demonstrated a beneficial clinical response (for example, increased platelet counts), according to the prescriber?
11. ☐ Yes ☐ No Does the patient remain at risk for bleeding complications?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

If you have any questions, call: 800-753-2851

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851