maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Doptelet

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1 What is the diagnosis or indication?
[] Thrombocytopenia in patients with chronic liver disease (If checked, go to 2)

[] Chronic immune thrombocytopenia (If checked, go to 5)

[] Other (If checked, no further questions)

2 What is the patient's age?
[] Greater than or equal to 18 years of age (If checked, go to 3)

[] Less than 18 years of age (If checked, no further questions)

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

3	Does the patient have a current platelet count of less than 50 x 10^9/L (less than 50,000 per microliter)? [If no, no further questions.]	Yes	No
4	Is the patient scheduled to undergo a procedure within 10 to 13 days after starting Doptelet therapy? [No further questions.]	Yes	No
5	Is the request for initial therapy or continuation of therapy? [] Initial therapy (If checked, go to 6) [] Continuation of therapy (If checked, go to 12)		
6	What is the patient's age? [] Greater than or equal to 18 years of age (If checked, go to 7) [] Less than 18 years of age (If checked, no further questions)		
7	Is the requested medication prescribed by or in consultation with a hematologist? [If no, no further questions.]	Yes	No
8	Has the patient tried one other therapy? [Note: Examples of therapies are systemic corticosteroids, intravenous immunoglobulin, anti-D immunoglobulin, Promacta (eltrombopag tablets and oral suspension), Nplate (romiplostim injection for subcutaneous use), Tavalisse (fostamatinib tablets), and rituximab.] [If yes, skip to question 10.]	Yes	No
9	Has the patient undergone a splenectomy? [If no, no further questions.]	Yes	No
10	Does the patient have a platelet count of less than 30 x 10^9/L (less than 30,000/microliter)? [If yes, no further questions.]	Yes	No
11	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? [No further questions.]	Yes	No
12	Has the patient demonstrated a beneficial clinical response (for example, increased platelet counts), according to the prescriber? [If no, no further questions.]	Yes	No
13	Does the patient remain at risk for bleeding complications?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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