maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Cablivi

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	What is the diagnosis or indication? [] Acquired Thrombotic Thrombocytopenia Purpura (aTTP) (If checked, go to 2) [] Other (If checked, no further questions)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 13.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication?	Yes	No

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

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	[If yes, skip to question 9.]		
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 9.]	Yes	No
5	Has documentation been submitted to confirm that the patient has ADAMTS13 activity level less than 10%? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Has documentation been submitted to confirm that the patient has recurrent thrombocytopenia after initial recovery of platelet count (greater than or equal to 150,000/uL) that required initiation of daily plasma exchange that occurred after 30-day post daily plasma exchange period? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Has documentation been submitted to confirm that the patient has NOT had more than 2 recurrences of Acquired Thrombotic Thrombocytopenia Purpura (aTTP) during treatment? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	Has documentation been submitted to confirm that the requested medication is being prescribed by or in consultation with a hematologist? ACTION REQUIRED: Submit supporting documentation. [NOTE: Reauthorization approvals are for subcutaneous maintenance injections only.] [No further questions.]	Yes	No
9	Has documentation been submitted to confirm that the patient has only received the initial 30-day treatment course? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Has documentation been submitted to confirm that the patient has ADAMTS13 activity level less than 10%? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Has documentation been submitted to confirm that the patient has recurrent thrombocytopenia after initial recovery of platelet count (greater than or equal to 150,000/uL) that required initiation of daily plasma exchange that occurred after 30-day post daily plasma exchange period? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[If no, no further questions.]		
12	Has documentation been submitted to confirm that the patient has NOT had more than 2 recurrences of Acquired Thrombotic Thrombocytopenia Purpura (aTTP) during treatment? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Has documentation been submitted to confirm that the patient is greater than or equal to 18 years of age? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Has documentation been submitted to confirm that the requested medication is being prescribed by or in consultation with a hematologist? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Has documentation been submitted to confirm that the patient has a PLASMIC score of 6-7? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Has documentation been submitted to confirm that the patient has a platelet count less than 30,000/uL? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Has documentation been submitted to confirm that the patient has hemolysis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
18	Has documentation been submitted to confirm that the patient has a mean corpuscular volume (MCV) less than 90 fL? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Has documentation been submitted to confirm that the patient has an international normalized ratio (INR) less than 1.5? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Has documentation been submitted to confirm that the patient has a creatinine less than 2.0 mg/dL? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Has documentation been submitted to confirm that the patient has active cancer? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
22	Has documentation been submitted to confirm that the patient has a history of	Yes	No

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	solid-organ or stem-cell transplant? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
23	Has documentation been submitted to confirm that the requested medication will be used in combination with plasma exchange therapy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	Has documentation been submitted to confirm that the requested medication will be used in combination with immunosuppressive therapy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Has documentation been submitted to confirm that the requested dose is within the manufacturer's dosing guidelines (based on diagnosis etc.) listed in the FDA approved labeling? ACTION REQUIRED: Submit supporting documentation. [NOTE: Initial approvals are for a single IV induction dose & subcutaneous maintenance injections.]	Yes	No

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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