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. 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 Is the request for an INITIAL or a CONTINUATION of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? [If no, skip to question 7.] Yes No

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

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		Yes	No
3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
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 7.]	Yes	No
5	Has the patient been established on therapy for AT LEAST 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? [] Thrombocytopenia in patients with chronic liver disease (If checked, go to 8) [] Chronic immune thrombocytopenia (If checked, go to 12) [] Other (If checked, no further questions)		
8	What is the patient's age? [] Greater than or equal to 18 years of age (If checked, go to 9) [] Less than 18 years of age (If checked, no further questions)		
9	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
10	Is the patient scheduled to undergo a procedure within 10 to 13 days after starting the requested therapy? [If no, no further questions.]	Yes	No
11	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [Dosing: Platelet count 40,000 to less than 50,000/mm3: 40 mg once daily for 5 days; Platelet count less than 40,000/mm3: 60 mg once daily for 5 days.] [No further questions.]	Yes	No
12	What is the patient's age? [] Greater than or equal to 18 years of age (If checked, go to 13) [] Between 1 year of age to less than 18 years of age (If checked, go to 17)		

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[] Less than 1 year of age (If checked, no further questions)

13 Has the patient tried ONE other therapy? Yes No
[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 15.]

14 Has the patient undergone a splenectomy? Yes No
[If no, no further questions.]

15 Does the patient have a platelet count of less than 30 x 10^9/L (less than 30,000/microliter)? Yes No
[If yes, skip to question 20.]

16 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? Yes No
[If yes, skip to question 20.]
[If no, no further questions.]

17 Has the patient tried ONE other therapy? Yes No
[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 no, no further questions.]

18 Does the patient have a platelet count of less than 30 x 10^9/L (less than 30,000/microliter)? Yes No
[If yes, skip to question 20.]

19 Does the patient have a platelet count of less than 35 x 10^9/L (less than 35,000/microliter) and is at an increased risk of bleeding, according to the prescriber? Yes No
[If no, no further questions.]

20 Is the requested medication prescribed by or in consultation with a hematologist? Yes No
[If no, no further questions.]

21 What medication is being requested?
[] Doptelet tablet (If checked, go to 23)

[] Doptelet capsule sprinkle (If checked, go to 22)

22 Is the patient unable to swallow capsules/tablets? ACTION REQUIRED: Submit Yes No

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	supporting documentation. [If no, no further questions.]		
23	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [Dosing: Max of up to 40 mg once daily.]	Yes	No

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

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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.