CVS caremark™ {{PANUMCODE}}

Doptelet

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** 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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   - ❑ Chronic immune thrombocytopenia (ITP)
   - ❑ Thrombocytopenia in chronic liver disease
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the requested drug prescribed by or in consultation with a hematologist, hepatologist, or gastroenterologist? *Indicate all the apply.*
   - ❑ Yes - hematologist
   - ❑ Yes - hepatologist
   - ❑ Yes - gastroenterologist
   - ❑ No - none of the above
4. Will the requested drug be used concurrently with other thrombopoietin receptor agonists (e.g., Mulpleta, Promacta, Nplate) or with spleen tyrosine kinase inhibitors (e.g., Tavalisse)? ❑ Yes ❑ No

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

Section A: Chronic Immune Thrombocytopenia (ITP)

5. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #10*
6. What is the patient's current platelet count? ***ACTION REQUIRED: Attach laboratory documentation or chart notes with current platelet count.*** _____/mcL or 10^9/L *(circle one)* ❑ Unknown
   If 50,000 to 200,000/mcL (50x10^9 to 200x10^9/L), no further questions.
   If greater than 200,000/mcL (greater than 200x10^9/L) to less than or equal to 400,000/mcL (400x10^9/L), skip to #9
7. Is the platelet count sufficient to prevent clinically important bleeding?
   If Yes, no further questions. ❑ Yes ❑ No
8. Has the patient received a maximal dose of the requested drug for at least 4 weeks?
   ❑ Yes ❑ No *No further questions.*

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9. Will dosing be adjusted to achieve a platelet count sufficient to avoid clinically important bleeding?
   ❑ Yes ❑ No *No further questions.*

10. Has the patient had an inadequate response or is intolerant to prior therapy for chronic immune thrombocytopenia (for example, corticosteroids or immunoglobulins)? ❑ Yes ❑ No

11. What is/was the lowest untransfused platelet count prior to the initiation of any ITP therapy?
    ACTION REQUIRED: Attach laboratory documentation or chart notes with untransfused platelet count prior to the initiation of ITP therapy. _____/mcL or 10^9/L *(circle one)* ❑ Unknown
    If less than 30,000/mcL (less than 30x10^9/L), no further questions.

12. Does the patient have symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma) or risk factors for bleeding? ❑ Yes ❑ No
    Examples of risk factors (not all inclusive):
    a) Undergoing a medical or dental procedure where blood loss is anticipated
    b) Comorbidity (e.g., peptic ulcer disease or hypertension)
    c) Mandated anticoagulation therapy
    d) Profession (e.g., construction worker) or lifestyle (e.g., plays contact sports) that predisposes patient to trauma

Section B: Thrombocytopenia in Chronic Liver Disease

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

14. Has the patient been scheduled to undergo a new procedure since the last prior authorization approval?
    ❑ Yes ❑ No

15. What is the patient's untransfused platelet count (taken within 14 days of the request)?
    ACTION REQUIRED: Attach laboratory documentation or chart notes with platelet count taken within 14 days of the request. _____/mcL or 10^9/L *(circle one)* ❑ Unknown

16. Is the patient scheduled to undergo a procedure? ❑ 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)**

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