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: _____ Date: _____
Patient's ID: _____ Patient's Date of Birth: _____
Physician's Name: _____
Specialty: _____ NPI#: _____
Physician Office Telephone: _____ Physician Office Fax: _____
Request Initiated For: _____

1. Is the product being requested for the treatment of one of the following indications?
   ❑ Chronic or persistent primary immune thrombocytopenia (ITP)
   ❑ Thrombocytopenia in chronic liver disease
   ❑ Severe thrombocytopenia post cancer chemotherapy
   ❑ Other _____

2. What is the ICD-10 code? _____

3. These are the preferred products for which coverage is provided for the treatment of the following indications:
   a) Thrombocytopenia in chronic liver disease: Mulpleta
   b) Thrombocytopenia in chronic immune thrombocytopenia: Promacta and Nplate
   Can the patient's treatment be switched to a preferred product?
   ❑ Yes - Please specify: _____ ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ No - Continue request non-formulary product

4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #6*

5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No

6. Does the patient have a documented inadequate response or intolerable adverse event to treatment with the any of the preferred products? ***ACTION REQUIRED: If Yes, indicate ALL that apply and attach supporting chart note(s).*** ❑ Yes - Mulpleta ❑ Yes - Promacta ❑ Yes - Nplate ❑ No
   If No, complete this form in its entirety and State Step Therapy section..

7. 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

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155

 Doptelet State Step, sNTM SGM - 12/2020.

CVS Caremark Prior Authorization ● 1300 E. Campbell Road ● Richardson, TX 75081
Phone: 1-866-814-5506 ● Fax: 1-866-249-6155 ● www.caremark.com

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

Section A: Chronic or Persistent Primary Immune Thrombocytopenia (ITP)

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

9. 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 (less than or equal to $400x10^9$/L), skip to #13

10. Is the platelet count sufficient to prevent clinically important bleeding?
    If Yes, no further questions. ❑ Yes ❑ No

11. Has the patient received a maximal dose of the requested drug for at least 4 weeks?
    ❑ Yes ❑ No *No further questions*

12. Will dosing be reduced to obtain a platelet count sufficient to avoid clinically important bleeding?
    ❑ Yes ❑ No *No further questions*

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

14. What is/was the untransfused platelet count at the time of diagnosis? ***ACTION REQUIRED: Attach laboratory documentation or chart notes with untransfused platelet count at the time of diagnosis.***
    _____ mcL or 10^9/L ***(circle one)*** ❑ Unknown
    If less than 30,000/mcL (less than $30x10^9$/L), no further questions.

15. 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

16. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #19*

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

18. What is the patient's baseline 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

19. Is the patient scheduled to undergo a procedure? ❑ Yes ❑ No

Section C: Severe Thrombocytopenia Post Cancer Chemotherapy

20. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #22*

21. Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)? ❑ Yes ❑ No

22. 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

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No
2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No
3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*
4. Is the alternate drug (see below) FDA-approved for the medical condition being treated? ❑ Yes ❑ No *If No, please specify:* _____
5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*
6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*
7. Are any of the following conditions met for the alternate drug (see below)?
   ❑ The alternate drug is contraindicated
   ❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
   ❑ The alternate drug is expected to be ineffective
   ❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
   ❑ The alternate drug is not in the patient's best interest
   ❑ The alternate drug was tried while covered by the current or the previous health benefit plan
   ❑ None of the above
   If Yes, please specify: _____
8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ Yes ❑ No

Alternative drug(s) based on diagnosis:
a) Thrombocytopenia in chronic liver disease: **Mulpleta**
b) Thrombocytopenia in chronic immune thrombocytopenia: **Promacta and Nplate**

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.

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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