Nplate

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID**_____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: ❑ **Same as Requesting Provider** **HPHC Provider ID:**_____
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **Provider Tax ID:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Criteria Questions:

1. What drug is being prescribed? ❑ Nplate ❑ Other _____

2. What is the diagnosis?
   ❑ Cyclic thrombocytopenia
   ❑ Chronic or persistent primary immune thrombocytopenia (ITP)
   ❑ Severe aplastic anemia
   ❑ Thrombocytopenia associated with chronic hepatitis C
   ❑ MYH9-related disease with thrombocytopenia
   ❑ Other _____

3. What is the ICD-10 code? _____

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

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

4. Is the request for a continuation of therapy with the requested product? ❑ Yes ❑ 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, *skip to #9*

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6. Has the patient tried and had an inadequate response or is intolerant to corticosteroids, immunoglobulins, or splenectomy? ❑ Yes ❑ No

7. What is/was the untransfused platelet count at the time of diagnosis?
   Indicate pre-treatment results: _____ /mcL or $x10^9$/L ***(circle one)***
   If less than 30,000/mcL (less than $30x10^9$/L), no further questions

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

9. What is the current platelet count?
   Indicate current results: _____ /mcL or $x10^9$/L ***(circle one)***
   If less than 200,000/mcL ($200x10^9$/L), no further questions.

10. Will the dose be adjusted to achieve a platelet count sufficient to avoid clinically important bleeding? ❑ 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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