



## 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.

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](mailto: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: \_\_\_\_\_ 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

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-844-851-0882**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Nplate HPHC - 04/2018.

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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  $\times 10^9/L$  (**circle one**)  
*If less than 30,000/mcL (less than  $30 \times 10^9/L$ ), 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  $\times 10^9/L$  (**circle one**)  
*If less than 200,000/mcL ( $200 \times 10^9/L$ ), 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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