Nplate, Promacta

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.

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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. What drug is being prescribed?
   ❑ Nplate ❑ Promacta ❑ Other _____
2. What is the diagnosis?
   ❑ Chronic or persistent primary immune thrombocytopenia (ITP)
   ❑ Thrombocytopenia associated with chronic hepatitis C
   ❑ Aplastic anemia
   ❑ Myelodysplastic syndrome
   ❑ MYH9-related disease with thrombocytopenia
   ❑ Severe thrombocytopenia post cancer chemotherapy
   ❑ Other _____
3. What is the ICD-10 code? _____
4. Will the requested drug be used concurrently with other thrombopoietin receptor agonists (e.g., Nplate, Promacta, Doptelet, Mulpleta) or with spleen tyrosine kinase inhibitors (e.g., Tavalisse)? ❑ Yes ❑ No

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

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

5. Is the request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #7*
6. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If No, skip to #10*
7. Has the patient had an inadequate response or is intolerant to corticosteroids, immunoglobulins, or splenectomy?
   ❑ Yes ❑ No
8. What is/was the lowest untransfused platelet count at any point prior to the initiation of the requested medication?
   ACTION REQUIRED: Attach laboratory documentation or chart notes with untransfused platelet count prior to the initiation of ITP therapy.
   Indicate pre-treatment results: _____ /mcL or $x10^9$/L ***(circle one)*** ❑ Unknown
   If less than 30,000/mcL (less than $30x10^9$/L), no further questions.

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9. Does the patient have symptomatic bleeding (e.g., 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 (e.g., peptic ulcer disease or hypertension)
   - Mandated anticoagulation therapy
   - Profession (e.g., construction worker) or lifestyle (e.g., plays contact sports) that predisposes patient to trauma

10. What is the patient's current platelet count? ***ACTION REQUIRED: Attach laboratory documentation or chart notes with current platelet count.***
    Indicate current results: _____ /mcL or $x10^9$/L ***(circle one)*** ❑ Unknown
    If greater than or equal to 50,000 to less than or equal to 200,000 ($50x10^9$ to $200x10^9$/L), no further questions.

11. *If less than 50,000/mcL (less than $50x10^9$/L),* is the platelet count sufficient to prevent clinically important bleeding? *If Yes, no further questions.* ❑ Yes ❑ No

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

13. *If greater than 200,000/mcL ($200x10^9$/L) to less than or equal to 400,000/mcL (less than or equal to $400x10^9$/L),* will dosing be reduced to obtain a platelet count sufficient to avoid clinically important bleeding? ❑ Yes ❑ No

Section B: Thrombocytopenia Associated with Chronic Hepatitis C (Promacta Only)

14. Is the request for continuation of therapy with Promacta? ❑ Yes ❑ No *If No, skip to #16*

15. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No ❑ Unknown *If No, skip to #17*

16. Will Promacta be used to initiate and maintain interferon-based therapy? ❑ Yes ❑ No *No further questions*

17. Is the patient still receiving interferon-based therapy? ❑ Yes ❑ No

Section C: Aplastic Anemia (Promacta Only)

18. Is the request for continuation of therapy with Promacta? ❑ Yes ❑ No *If No, skip to #20*

19. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If No, skip to #23*

20. Will Promacta be used as first-line treatment of severe aplastic anemia? ❑ Yes ❑ No *If No, skip to #22*

21. Will Promacta be used in combination with standard immunosuppressive therapy (e.g., horse antithymocyte globulin (h-ATG) and cyclosporine)? ❑ Yes ❑ No *No further questions*

22. Has the aplastic anemia been previously treated with immunosuppressive therapy?
    ❑ Yes ❑ No *No further questions*

23. What is the current platelet count? ***ACTION REQUIRED: Attach laboratory documentation or chart notes with current platelet count.***
    Indicate current results: _____ /mcL or $x10^9$/L ***(circle one)*** ❑ Unknown
    If between 50,000 to 200,000/mcL ($50x10^9$ to $200x10^9$/L), no further questions

24. *If less than 50,000/mcL ($50x10^9$/L),* is the patient transfusion-independent? *If Yes, please provide how many weeks of therapy the patient has received and no further questions.*
    ❑ Yes, *specify number of weeks*: _____ ❑ No

25. Has the patient received appropriately titrated therapy for at least 16 weeks? If no, please provide how many weeks of therapy the patient has received.
    ❑ Yes ❑ No, *specify number of weeks:*_____ *No further questions*

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26. *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),* will dosing be reduced to achieve and maintain an appropriate target platelet count?
❑ Yes ❑ No

Section D: Myelodysplastic Syndrome

27. Is the request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #29*

28. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If No, skip to #31*

29. Does the patient have lower risk disease, defined as Revised International Prognostic Scoring System (IPSS-R) (Very Low, Low, Intermediate), International Prognostic Scoring System (IPSS) (Low/Intermediate-1), WHO classification-based Prognostic Scoring System (WPSS) (Very Low, Low, Intermediate)? ❑ Yes ❑ No

30. Does the patient have severe or refractory thrombocytopenia following disease progression or no response to hypomethylating agents (such as azacitidine and decitabine) or immunosuppressive therapy?
❑ Yes ❑ No *No further questions*

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

Section E: Severe Thrombocytopenia Post Cancer Chemotherapy

32. What is the current platelet count? ***ACTION REQUIRED: Attach laboratory documentation or chart notes with current platelet count.***
Indicate current results: _____ /mcL **OR** x10^9/L ***(circle one)*** ❑ Unknown

33. Is the request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, no further questions.*

34. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? *If Yes or Unknown, no further questions.* ❑ Yes ❑ No ❑ Unknown

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

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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