



**Nplate, Promacta
Prior Authorization Request**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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 1-855-330-1720.** 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:** _____

Referring Provider Info: Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

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

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**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062
Phone: 1-866-814-5506 • Fax: 1-855-330-1720 • www.caremark.com**

Criteria Questions:

1. What drug is being prescribed? Nplate Promacta 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
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: _____/mL 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: _____/mL 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

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

11. Is the request for a continuation of therapy with the requested product? Yes No, skip to #13
12. 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 #14
13. Is the patient still receiving interferon-based therapy? Yes No *No further questions*
14. Will Promacta be used to initiate and maintain interferon-based therapy? Yes No

Section C: Severe Aplastic Anemia (Promacta Only)

15. Is the request for a continuation of therapy with the requested product? Yes No, no further questions
16. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes'. Yes, no further questions No
17. What is the current platelet count?
Indicate current results: _____/mL or $\times 10^9/L$ (**circle one**)
If between 50,000 to 200,000/mcL (50×10^9 to $200 \times 10^9/L$), no further questions
18. *If less than 50,000/mcL ($50 \times 10^9/L$), is the patient transfusion-independent?*

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If Yes, no further questions Yes No

19. Has the patient received appropriately titrated therapy for at least 16 weeks?
 Yes No

20. *If greater than 200,000/mcL (200x10⁹/L)*, will dosing be adjusted to achieve and maintain an appropriate target platelet count? 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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