Doptelet (avatrombopag)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA. ☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Chronic liver disease undergoing a procedure □ Idiopathic thrombocytopenia(ITP) □ Other diagnosis: _____ICD-10 Code(s): _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Is prescriber one of the below? □ Yes □ No :
□ Hematologist/oncologist □ Gastroenteroloist □ Hepatologist

<u>For patients with chronic liver disease AND undergoing a procedure:</u>

Is the patient going to have one of the below procedures? □ Yes □ No *Please circle one.*

- paracentesis
- thoracentesis
- gastrointestinal endoscopy
- liver biopsy
- bronchoscopy
- ethanol ablation therapy
- chemoembolization
- vascular catheterization
- transjugular intrahepatic portosystemic shunt
- dental procedure
- renal biopsy
- biliary intervention
- nephrostomy tube placement
- radiofrequency ablation
- laparoscopic intervention

Is patient's chronic liver disease Model for End-stage liver disease(MELD) score <u>< 24</u>? □ Yes □ No *Please submit chart documentation.*

Is patient's thrombocytopenia mean baseline platelet count less than 50,000? □ Yes □ No *Please submit chart documentation.*

<u>For patient's with idiopathic thrombocytopenia(ITP):</u>

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Has the patient been diagnosed with idiopathic thrombocytopenia(ITP) for at least 12months or longer? □ **Yes** □ **No** ***Please submit chart documentation.***

Is patient's platelet count less than 30,000 on two consecutive draws? □ **Yes** □ **No** ***Please submit chart documentation that includes the date & # measured most recently, & the date & # measured preceding that count.***

Were the platelets on the CBC described as being "clumped: on either of these blood samples □ **Yes** □ **No**

Is patient's platelet count less than 50,000 and considered to be at high risk of bleeding? ? □ **Yes** □ **No** ***Please submit chart documentation.***

Is patient known to have myelodysplastic syndrome? □ **Yes** □ **No**

Does patient have an absolute contraindication to corticosteroids? □ **Yes** □ **No** ***Please submit chart documentation.***

Has patient had a trial and insufficient response to corticosteroids? □ **Yes** □ **No** ***Please submit chart documentation.***

Does patient have an absolute contraindication to immunoglobulins? □ **Yes** □ **No** ***Please submit chart documentation.***

Has patient had a trial and insufficient response to immunoglobulins? □ **Yes** □ **No** ***Please submit chart documentation.***

Does patient have an absolute contraindication to a splenectomy? □ **Yes** □ **No** ***Please submit chart documentation.***

Has patient had a splenectomy? □ **Yes** □ **No** ***Please submit chart documentation.***

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811