



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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> 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? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES: <input type="checkbox"/> Chronic liver disease undergoing a procedure <input type="checkbox"/> Idiopathic thrombocytopenia(ITP) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____		ICD-10:
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Clinical Information: Is prescriber one of the below? <input type="checkbox"/> Yes <input type="checkbox"/> No : <input type="checkbox"/> Hematologist/oncologist <input type="checkbox"/> Gastroenteroloist <input type="checkbox"/> Hepatologist <u>For patients with chronic liver disease AND undergoing a procedure:</u> Is the patient going to have one of the below procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please circle one.</i> <ul style="list-style-type: none"> <input type="radio"/> paracentesis <input type="radio"/> thoracentesis <input type="radio"/> gastrointestinal endoscopy <input type="radio"/> liver biopsy <input type="radio"/> bronchoscopy <input type="radio"/> ethanol ablation therapy <input type="radio"/> chemoembolization <input type="radio"/> vascular catheterization <input type="radio"/> transjugular intrahepatic portosystemic shunt <input type="radio"/> dental procedure <input type="radio"/> renal biopsy <input type="radio"/> biliary intervention <input type="radio"/> nephrostomy tube placement <input type="radio"/> radiofrequency ablation <input type="radio"/> laparoscopic intervention Is patient's chronic liver disease Model for End-stage liver disease(MELD) score \leq 24? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit chart documentation.</i> Is patient's thrombocytopenia mean baseline platelet count less than 50,000? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit chart documentation.</i>		





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For patient's with idiopathic thrombocytopenia(ITP):

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:** _____





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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

