

THROMBOPOIETIN RECEPTOR AGONISTS TAVALISSE WAYRILZ

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis: <input type="checkbox"/> Immune (idiopathic) thrombocytopenia (ITP) <input type="checkbox"/> Hematopoietic syndrome of acute radiation syndrome (HS-ARS) <input type="checkbox"/> Hepatitis C associated thrombocytopenia <input type="checkbox"/> Severe aplastic anemia <input type="checkbox"/> Thrombocytopenia AND chronic liver disease <input type="checkbox"/> Other (ICD code and description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<p>For all requests:</p> <p>1. What is the patient’s weight? _____ (kg)</p> <p>2. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Does the patient have any FDA labeled contraindications to the requested agent? A contraindication is a medical situation where a treatment should be avoided because it could cause harm to a person..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____</p> <p>4. Is the patient’s age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is there support for using the requested agent for the patient’s age for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____</p> <p>5. Will the patient be using the requested agent in combination with another agent included in this program (i.e., Alvaiz, Doptelet/Doptelet sprinkle, Mulpleta, Nplate, Promacta, Tavalisse, Wayrilz)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify agent: _____</p> <p>6. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____</p>	
<p>Please continue to the next page.</p>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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7. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No
- If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration?..... Yes No
- If no, is there documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? Please note, chart notes are required. Yes No
- If yes, please submit chart notes.
- If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration?..... Yes No

For hepatitis C associated thrombocytopenia requests:

8. Is the intent of therapy with the requested agent to increase platelet count sufficiently to initiate interferon therapy? Yes No
- If yes, is the patient's baseline (prior to therapy with the requested agent) platelet count less than $75 \times 10^9/L$? Yes No
9. Is the patient on concomitant therapy with interferon? Yes No
- If yes, is the patient at risk for discontinuing hepatitis C therapy due to thrombocytopenia?..... Yes No

For immune (idiopathic) thrombocytopenia (ITP) requests:

10. Please select what best describe the patient's diagnosis.
- Chronic - defined as having lasted for more than 12 months
 - Persistent - defined as having lasted for at least 3 months but not more than 12 months
11. If the request is for Nplate and patient is pediatric, has the patient's diagnosis lasted for at least 6 months? Yes No
12. Does the patient have a baseline (prior to therapy with the requested agent) platelet count less than or equal to $30 \times 10^9/L$? Yes No
13. Does the patient have a baseline (prior to therapy with the requested agent) platelet count greater than $30 \times 10^9/L$ but less than $50 \times 10^9/L$? Yes No
- If yes, does the patient have symptomatic bleeding and/or an increased risk for bleeding?..... Yes No
14. Has the patient tried and had an inadequate response to another thrombopoietin receptor agonist (e.g., Doptelet, Nplate, Promacta) or Tavalisse? Yes No
- If yes, please specify agent tried: _____
15. Has the patient tried and had an inadequate response to immunoglobulins (IVIg or Anti-D)? Yes No
16. Has the patient had an inadequate response to a splenectomy? Yes No
17. Has the patient tried and had an inadequate response to rituximab?..... Yes No
18. Has the patient tried and had an inadequate response to ONE corticosteroid used for the treatment of ITP?..... Yes No
- If no, does the patient have an intolerance or hypersensitivity to ONE corticosteroid used for the treatment of ITP?..... Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- _____
- If no, does the patient have an FDA labeled contraindication to ALL corticosteroids used for the treatment of ITP? Yes No
- If yes, please specify contraindication(s): _____
- _____

For severe aplastic anemia requests:

19. Does the patient have at least 2 of the following baseline (prior to therapy with the requested agent) blood criteria? Check all that apply.
- Neutrophils less than $0.5 \times 10^9/L$
 - Platelets less than $30 \times 10^9/L$
 - Reticulocyte count less than $60 \times 10^9/L$
 - None of the above

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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20. Does the patient have 1 of the following marrow criteria? Check all that apply.

Severe hypocellularity (i.e., less than 25%)

Moderate hypocellularity (i.e., 25-50%) with hematopoietic cells representing less than 30% of residual cells

None of the above

21. Has the patient tried and had an inadequate response to BOTH antithymocyte globulin (ATG) AND cyclosporine therapy? Yes No

If no, does the patient have an intolerance or hypersensitivity to BOTH ATG AND cyclosporine? Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to BOTH ATG AND cyclosporine? Yes No

If yes, please specify contraindication(s): _____

22. If the request is for Promacta, will the patient use the requested agent as first-line treatment? Yes No

If no, will the patient use the requested agent in combination with standard immunosuppressive therapy (i.e., antithymocyte globulin [ATG] AND cyclosporine)? Yes No

For thrombocytopenia and chronic liver disease requests:

23. Does the patient have a baseline (prior to therapy with the requested agent) platelet count of less than 50 x 10⁹/L? Yes No

24. Is the patient scheduled to undergo a procedure with an associated risk of bleeding (e.g., gastrointestinal endoscopy, liver biopsy, bronchoscopy, dental procedure)? Yes No

25. Would the patient require a platelet transfusion unless platelet counts are clinically increased from baseline (prior to therapy with the requested agent)? Yes No

For renewal requests:

26. Has the patient had clinical benefit with the requested agent? Yes No

For hepatitis C associated thrombocytopenia requests:

27. Will the patient be initiating or maintaining hepatitis C therapy with interferon? Yes No

28. Is the patient's platelet count greater than or equal to 90 x 10⁹/L? Yes No

If no, has the patient's platelet count increased sufficiently to initiate or maintain interferon therapy for the treatment of hepatitis C? Yes No

For immune (idiopathic) thrombocytopenia (ITP) requests:

29. Is the patient's platelet count greater than or equal to 50 x 10⁹/L? Yes No

31. Has the patient's platelet count increased sufficiently to avoid clinically significant bleeding? Yes No

Please fax or mail this form to:
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 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121
TOLL FREE

Phone: **Fax: 877.243.6930**

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BCBSNM: 800.544.1378

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