Nplate

HMSACOM - 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 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

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

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

 Nplate HMSACOM C16799-A – 04/2025.

Criteria Questions:

1. Will the requested drug be used concurrently with other thrombopoietin receptor agonists (e.g., Promacta, Doptelet, Mulpleta) or with spleen tyrosine kinase inhibitors (e.g., Tavalisse)?

❒ Yes, *Continue to #2*

❒ No, *Continue to #2*

2. Is the requested drug being prescribed by, or in consultation with, a hematologist or oncologist?

❒ Yes, *Continue to #3*

❒ No, *Continue to #3*

3. Is the request for continuation of therapy with Nplate?

❒ Yes, *Continue to #4*

❒ No, *Continue to #5*

4. Is the patient currently receiving the requested product through samples or manufacturer's patient assistance program?

❒ Yes, *Continue to #5*

❒ No, *Continue to #11*

❒ Unknown, *Continue to #5*

5. What is the diagnosis?

❒ Immune thrombocytopenia (ITP), *Continue to #6*

❒ Hematopoietic syndrome of acute radiation syndrome (acute exposure to myelosuppressive doses of radiation), *No Further Questions*

❒ Myelodysplastic syndrome, *No Further Questions*

❒ Chemotherapy-induced thrombocytopenia (CIT), *Continue to #9*

❒ Other, *No Further Questions*

Initial Therapy

ITP

6. Has the patient had an inadequate response or is intolerant to prior therapy with corticosteroids, immunoglobulins, or splenectomy? ***Documentation required: All previous drug therapies should be submitted***

❒ Yes, *Continue to#7*

❒ No, *Continue to#7*

7. What is/was the lowest untransfused platelet count at any point prior to the initiation of the requested medication? ***Documentation required: Platelet counts must be submitted***

❒ Less than 30,000/mcL (30x109/L), *No Further Questions*

❒ 30,000 to 50,000/mcL (30x109 to 50x109/L), *Continue to #8*

❒ Greater than 50,000/mcL (50x109/L), *Continue to #8*

❒ Unknown, *Continue to #8*

8. Does the patient have symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma) or risk factors for bleeding?
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) predisposes the patient to trauma

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

CIT

9. Has the patient's platelet count remained less than 100,000/mcL (100x109/L) for at least 3-4 weeks following the last chemotherapy administration? ***Action Required: Attach laboratory documentation or chart notes with current platelet count***

❒ Yes, *No Further Questions*

❒ No, *Continue to #10*

10. Has chemotherapy administration been delayed related to thrombocytopenia?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Continuation

ITP

11. What is the diagnosis?

❒ Immune thrombocytopenia (ITP), *Continue to #12*

❒ Hematopoietic syndrome of acute radiation syndrome (acute exposure to myelosuppressive doses of radiation), *No Further Questions*

❒ Myelodysplastic syndromes, *Continue to #16*

❒ Chemotherapy-induced thrombocytopenia (CIT), *Continue to #17*

12. What is the patient's current platelet count? ***Action Required***: ***Attach laboratory documentation or chart notes with current platelet count***

❒ Less than 50,000/mcL (less than 50x109/L), *Continue to #13*

❒ 50,000 to 200,000/mcL (50x109 to 200x109/L), *No Further Questions*

❒ Greater than 200,000/mcL (greater than 200x109/L) to less than or equal to 400,000/mcL (less than or equal to 400x109/L), *Continue to #15*

❒ Greater than 400,000/mcL (greater than 400x109/L), *No Further Questions*

❒ Unknown, *No Further Questions*

13. Is the platelet count sufficient to prevent clinically important bleeding?

❒ Yes, *No Further Questions*

❒ No, *Continue to #14*

14. Has the patient received a maximal dose of the requested drug for at least 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

15. Will dosing be adjusted to achieve a platelet count sufficient to avoid clinically important bleeding?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

MDS

16. Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

CIT

17. Is the requested drug being used to maintain dose schedule and intensity of chemotherapy?

❒ Yes, *Continue to #18*

❒ No, *Continue to #18*

18. Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)? ***Action Required***: ***Attach laboratory documentation or chart notes with current platelet count***

❒ Yes, *Continue to #19*

❒ No, *Continue to #19*

19. What is the patient's current platelet count?

❒ Less than 100,000/mcL (100x10^9/L), *No Further Questions*

❒ Greater than or equal to 100,000/mcL (100x10^9/L), *No Further Questions*

❒ Greater than 200,000mcL (200x10^9/L), *No Further Questions*

❒ Unknown, *No Further Questions*

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)**