Nplate

HMSA Medicare Advantage - 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

What is the ICD-10 code? _____

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

 Nplate HMSAMED C26253-A – 04/2025.

Criteria Questions:

1. What is the diagnosis?

❒ Immune thrombocytopenia (ITP), *Continue to #2*
❒ Hematopoietic syndrome of acute radiation syndrome (acute exposure to myelosuppressive doses of radiation), *No Further Questions*
❒ Myelodysplastic syndrome, *Continue to #30*
❒ Chemotherapy-induced thrombocytopenia, *Continue to #40*
❒ Other, *No Further Questions*

2. Is the patient currently receiving treatment with Nplate?

❒ Yes, *Continue to #3*
❒ No, *Continue to #15*

Immune thrombocytopenia - Continuation

3. What is the patient's current platelet count? Laboratory documentation or chart notes with current platelet count must be submitted upon request

❒ Less than 50,000/mcL (50x109/L), *Continue to #4*
❒ 50,000/mcL to 200,000/mcL (50x109/L to 200x109/L), *No Further Questions*
❒ Greater than 200,000/mcL (200x109/L) to less than or equal to 400,000/mcL (400x109/L), *Continue to #6*
❒ Greater than 400,000/mcL (400x109/L) , *No Further Questions*
❒ Unknown, *No Further Questions*

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

❒ Yes, *No Further Questions*
❒ No, *Continue to #5*

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

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Immune thrombocytopenia - Initial

15. Has the patient had a platelet count less than 30 x 109/L at any point prior to the initiation of the requested medication? ***Laboratory documentation or chart notes with pretreatment platelet count must be submitted upon request***

❒ Yes, *Continue to #18*
❒ No, *Continue to #16*

16. Has the patient had a platelet count less than 50 x 109/L at any point prior to the initiation of the requested medication? ***Laboratory documentation or chart notes with pretreatment platelet count must be submitted upon request***

❒ Yes, *Continue to #17*

❒ No, *Continue to #17*

17. Does the patient have symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma) or risk factors for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, mandated anticoagulation therapy, profession [e.g., construction worker] or lifestyle [e.g., plays contact sports] that predisposes patient to trauma)?

❒ Yes, *Continue to #18*

❒ No, *Continue to #18*

18. Has the patient previously received treatment with an immunoglobulin for the treatment of immune thrombocytopenia?

❒ Yes, *No Further Questions*

❒ No, *Continue to #19*

19. Has the patient had an inadequate response to corticosteroids (e.g., prednisone, methylprednisolone)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #20*

20. Has the patient undergone a splenectomy?

❒ Yes, *No Further Questions*

❒ No, *Continue to #21*

21. Is there a clinical reason to avoid treatment with both an immunoglobulin and corticosteroids (e.g., prednisone, methylprednisolone)? (Please provide the clinical reason in the space provided.)

_____

_____

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Myelodysplastic Syndromes (MDS)

30. Is the patient currently receiving treatment with Nplate?

❒ Yes, *Continue to #31*

❒ No, *Continue to #32*

31. Is the patient receiving benefit from therapy defined as increased platelet counts, decreased bleeding events or reduced need for platelet transfusions?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

MDS - Initial

32. Does the patient have lower risk disease, defined as Revised International Prognostic Scoring System (IPSS-R) (Very Low, Low, Intermediate), International Prognostic Scoring System (IPSS) (Low/Intermediate-1), WHO classification-based Prognostic Scoring System (WPSS) (Very Low, Low, Intermediate)?

❒ Yes, *Continue to #33*

❒ No, *Continue to #33*

33. Does the patient have severe or refractory thrombocytopenia following disease progression or no response to hypomethylating agents (such as azacitidine and decitabine), or immunosuppressive therapy?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Chemotherapy-Induced Thrombocytopenia (CIT)

40. Is the patient currently receiving treatment with Nplate?

❒ Yes, *Continue to #41*

❒ No, *Continue to #43*

41. Is the patient receiving benefit from therapy defined as increased platelet counts, decreased bleeding events or reduced need for platelet transfusions? ***Laboratory documentation or chart notes with current platelet count must be submitted upon request***

❒ Yes, *Continue to #42*

❒ No, *Continue to #42*

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

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

CIT - Initial

43. Has the patient's platelet count remained less than 100,000/mcL (less than 100x109/L) for at least 3-4 weeks following the last chemotherapy administration? ***Laboratory documentation or chart notes with platelet count prior to the initiation of CIT treatment must be submitted upon request***

❒ Yes, *No Further Questions*

❒ No, *Continue to #44*

44. Has chemotherapy administration been delayed related to thrombocytopenia?

❒ Yes, *No Further Questions*

❒ No, *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)**

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