**Send completed form to:**
**Case Review Unit**
**CVS Caremark Specialty Programs**
**Fax: 1-866-249-6155**

# Nplate, Promacta

## 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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: Caremark Connect® 1-800-237-2767.

**Patient Name:** _______________________ **Date:** _______________________
**Patient's ID:** _______________________ **Patient's Date of Birth:** _______________________
**Physician's Name:** _______________________
**Specialty:** _________________________________**, NPI#:** ___________________________
**Physician Office Telephone:** _______________________ **Physician Office Fax:** _______________________
**Physician Office Address:** _______________________

1. What drug is being prescribed? ❑ Nplate ❑ Promacta ❑ Other ________________

2. What is the diagnosis?
   ❑ Primary immune thrombocytopenia / immune (idiopathic) thrombocytopenic purpura (ITP)
   ❑ Cyclic thrombocytopenia
   ❑ Other _____________

3. What is the ICD-9? _____________

4. Is the patient currently receiving treatment with Nplate or Promacta? ❑ Yes ❑ No

***If the diagnosis is Cyclic Thrombocytopenia, no further questions.***

5. Has the patient been evaluated for other causes of thrombocytopenia? ❑ Yes ❑ No

6. Has the patient tried and had an insufficient response or is intolerant to corticosteroids, intravenous immunoglobulins, or splenectomy? If yes, then document previous therapies in PA notes. ❑ Yes ❑ No

7. Will liver function be measured at baseline and regularly throughout treatment?
   ❑ Yes ❑ No

8. Document or attach pretreatment LFTs.
   _________________________________________________________

9. What is/was the platelet count **at time of diagnosis**? ______________
   ❑ Less than 30,000/uL ( less than $30x10^9$/L )
   ❑ 30,000 to 50,000/uL ( $30x10^9$ to $50x10^9$/L )
   ❑ Greater than 50,000/uL ( greater than $50x10^9$/L )

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message.

**Patient Name:** {{MEMFIRST}} {{MEMLAST}} **Patient's Date of Birth:** {{MEMBERDOB}}
**Patient's ID** {{MEMBERID}}

10. Does the patient have symptomatic bleeding or risk factors for bleeding?
    *If yes, document the risk factors* ❑ Yes ❑ No
    ______________________________________________________

11. Are alanine aminotransferase (ALT) levels greater than or equal to 3x ULN with any one of the following characteristics? ❑ Yes ❑ No
    ❑ Progressive
    ❑ Persistent for greater than or equal to 4 weeks
    ❑ Accompanied by increased direct bilirubin
    ❑ Accompanied by clinical symptoms of liver injury or evidence for hepatic decompensation

12. What is the **current** platelet count? ______________
    ❑ Less than 50,000/uL ( less than $50x10^9$/L )
    ❑ 50,000 to 200,000/uL ( $50x10^9$ to $200x10^9$/L )
    ❑ Greater than 200,000/uL ( greater than $200x10^9$/L ) *Skip to #15*

13. Is the platelet count sufficient to prevent clinically important bleeding? ❑ Yes ❑ No

14. Has the patient received an optimal dose for at least 4 weeks? ❑ Yes ❑ No

15. Will therapy be adjusted to obtain the minimum platelet count needed to reduce the risk for bleeding? ❑ Yes ❑ No

*Information given on this form is accurate as of this date*

**X**______________________________________________________________
**Prescriber or Authorized Signature** **Date**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message.