Prior Authorization Request Form for avatrombopag (Doptelet)



JOHNS HOPKINS HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider				
Strength:				
Duration of Therapy:				

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Patient Name: Address: Sponsor ID# Date of Birth: Secure Fax #: Step Please complete the clinical assessment: 1. Is the patient greater than or equal to 18 years of age? Proceed to question 2 2. Has the patient been diagnosed with liver disease that has caused severe thrombocytopenia (platelet count less than 50 x 10 ⁹ /L)? 3. Does the patient have a diagnosis of chronic immune thrombocytopenia (ITP) and has had an insignificant response to previous therapy? 4. Is the patient scheduled to undergo a procedure with a moderate to high bleeding risk within 10-13 days after starting avatrom bopag? Phone #: Secure Fax #: Proceed to question 2 Yes Proceed to question 4 Proceed to question 4 Proceed to question 7 STOP Coverage not approcedure with a moderate to high bleeding risk within 10-13 days after starting avatrom bopag? Yes	Step	Please complete patient and physician information	n (please print):		
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		consultation with a gastroenterologist?	Sign and dat	e below	STOP
Coverage not appro					Coverage not approved

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	7. Has the patient tried and failed to Nplate or Promacta?	□ Yes	□ No	
		Proceed to question 10	Proceed to question 8	
	8. Does the patient have a contraindication to both Nplate AND Promacta?	☐ Yes	□ No	
-	AND Fromacta?	Proceed to question 10	Proceed to question 9	
	9. Is the patient expected to have an adverse effect to both Nplate and Promacta that would not be anticipated with avatrombopag (Doptelet)?	☐ Yes	□ No	
		Proceed to question 10	STOP	
			Coverage not approved	
	10. Is the requested medication being prescribed by or in	☐ Yes	□ No	
	consultation with a hematologist/oncologist?	Proceed to question 11	STOP	
			Coverage not approved	
	11. Is the requested medication being used at the same	☐ Yes	□ No	
	time with other chronic ITP therapy?	STOP	Sign and date below	
		Coverage not approved		
Step 3	I certify the above is true to the best of my knowle	edge. Please sign and d	ate:	
	Prescriber Signature	Date		
			.[8 April 2020]	
or Inter	nal Use Only			
Approv	ved:	Duration of Approval:month(s)		
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