Prior Authorization Request Form for avatrombopag (Doptelet)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	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.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Has the patient been diagnosed with liver disease that has caused severe thrombocytopenia (platelet count less than 50 x 10^9/L)?	☐ Yes Proceed to question **4**	☐ No Proceed to question **3**
3. Does the patient have a diagnosis of chronic immune thrombocytopenia (ITP) and has had an insignificant response to previous therapy?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
4. Is the patient scheduled to undergo a procedure with a moderate to high bleeding risk within 10-13 days after starting avatrombopag?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Does the patient show evidence of current thrombosis?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **6**
6. Is the requested medication being prescribed by or in consultation with a gastroenterologist?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

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7. Has the patient tried and failed to Nplate or Promacta?	☐ Yes Proceed to question **10**	☐ No Proceed to question **8**
8. Does the patient have a contraindication to both Nplate AND Promacta?	☐ Yes Proceed to question **10**	☐ No 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 Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Is the requested medication being prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **11**	☐ No **STOP** Coverage not approved
11. Is the requested medication being used at the same time with other chronic ITP therapy?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[8 April 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: