Prior Authorization Request Form for
lusutrombopag (**Mulpleta**)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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 requested medication being prescribed by or in consultation with a gastroenterologist?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Has the patient been diagnosed with liver disease that has caused severe thrombocytopenia (platelet less than 50 x 10^9/L)?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Will the patient be undergoing a procedure with a moderate to high bleeding risk within 8-14 days?	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**
5. Is there evidence of current thrombosis?	☐ 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

[6 March 2019]

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