



Nplate

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Referring Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ *kg*

Patient Height: _____ *cm*

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office

Drug Information:

Strength/Measure _____ *Units* ml Gm mg ea Un

Directions(sig) _____ *Route of administration* _____

Dosing frequency _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

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. Nplate SGM – 07/2021.

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Criteria Questions:

1. What is the diagnosis?
 Immune thrombocytopenia (ITP)
 Hematopoietic syndrome of acute radiation syndrome (acute exposure to myelosuppressive doses of radiation)
 Myelodysplastic syndrome
 Severe thrombocytopenia post cancer chemotherapy
 Other _____
2. What is the ICD-10 code? _____
3. Will the requested drug be used concurrently with other thrombopoietin receptor agonists (e.g., Promacta, Doptelet, Mulpleta) or with spleen tyrosine kinase inhibitors (e.g., Tavalisse)? Yes No

Complete the following questions based on the patient's diagnosis, if applicable.

Section A: Immune Thrombocytopenia (ITP)

4. Is the request for continuation of therapy with the requested product? Yes No *If No, skip to #6*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? Yes No Unknown *If No, skip to #9*
6. Has the patient had an inadequate response or is intolerant to corticosteroids, immunoglobulins, or splenectomy?
 Yes No
7. What is/was the lowest untransfused platelet count at any point prior to the initiation of the requested medication?
ACTION REQUIRED: Attach laboratory documentation or chart notes with untransfused platelet count prior to the initiation of ITP therapy.
Indicate pre-treatment results: _____/mcL or $\times 10^9/L$ (**circle one**) Unknown
If less than 30,000/mcL (less than $30 \times 10^9/L$), no further questions.
8. Does the patient have symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma) or risk factors for bleeding? Yes No *No further questions*
Examples of risk factors (not all inclusive):
 - Undergoing a medical or dental procedure where blood loss is anticipated
 - Comorbidity (e.g., peptic ulcer disease or hypertension)
 - Mandated anticoagulation therapy
 - Profession (e.g., construction worker) or lifestyle (e.g., plays contact sports) predisposes the patient to trauma
9. What is the patient's current platelet count? **ACTION REQUIRED: Attach laboratory documentation or chart notes with current platelet count.**
Indicate current results: _____/mcL or $\times 10^9/L$ (**circle one**) Unknown
If greater than or equal to 50,000 to less than or equal to 200,000/mcL (50×10^9 to $200 \times 10^9/L$), no further questions.
10. *If greater than 200,000/mcL (greater than $200 \times 10^9/L$) to less than or equal to 400,000/mcL (less than or equal to $400 \times 10^9/L$), will dosing be reduced to obtain a platelet count sufficient to avoid clinically important bleeding?*
 Yes No *No further questions*
11. *If less than 50,000/mcL (less than $50 \times 10^9/L$), is the platelet count sufficient to prevent clinically important bleeding?*
If Yes, no further questions. Yes No
12. Has the patient received a maximal dose of the requested drug for at least 4 weeks?
 Yes No *No further questions*

Section B: Myelodysplastic Syndrome

13. Is the request for continuation of therapy with the requested product? Yes No *If No, skip to #15*
14. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? Yes No Unknown *If No, skip to #17*

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15. 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 No
16. 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 *No further questions*
17. Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)? Yes No

Section C: Severe Thrombocytopenia Post Cancer Chemotherapy

18. Is the request for continuation of therapy with the requested product? Yes No *If No, skip to #21*
19. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? Yes No Unknown *If Yes or Unknown, skip to #21*
20. Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)? Yes No
21. What is the current platelet count? **ACTION REQUIRED: Attach laboratory documentation or chart notes with current platelet count.**
Indicate current results: _____ /mcL or x10⁹/L (**circle one**) Unknown

Section D: Hematopoietic Syndrome of Acute Radiation Syndrome (HSARS)

22. Will the requested drug be used concurrently with other thrombopoietin receptor agonists (e.g., Promacta, Doptelet, Mulpleta) or with spleen tyrosine kinase inhibitors (e.g., Tavalisse)? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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