Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (MEDICAID)

Mulpleta - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Mulpleta - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Mulpleta (lusutrombopag)

Quantity | Frequency | Strength

Route of Administration | Expected Length of Therapy

Patient Information

Patient Name: ______________________
Patient ID: ______________________
Patient Group No.: ______________________
Patient DOB: ______________________
Patient Phone:

Prescribing Physician

Physician Name: ______________________
Physician Phone: ______________________
Physician Fax: ______________________
Physician Address: ______________________
City, State, Zip: ______________________

Diagnosis: ______________________ **ICD Code:** ______________________

Comments: ______________________

Please circle the appropriate answer for each question.

1. Does the patient have a documented diagnosis of thrombocytopenia and chronic liver disease with platelet count less than 50 x 10^9/L? Y N

   NOTE: Submission of medical records is required.

   [If no, no further questions.]

2. Does the patient have documentation that the patient will be undergoing a procedure within 8 to 14 days after starting Mulpleta therapy? Y N

	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
3.	Does the patient have a documented insufficient response to the following therapies: a) corticosteroids and b) immunoglobulin?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
4.	Is the requested duration of use greater than 7 days?	Y N
	[If yes, no further questions.]	
5.	Is the patient 18 years of age or older?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date