Cablivi

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 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:** _____

Rendering 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 (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

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

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

What is the ICD-10 code? _____

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

Criteria Questions:

1. What is the diagnosis?

❒ Acquired thrombotic thrombocytopenic purpura (aTTP), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Has the patient experienced more than 2 recurrences of acquired thrombotic thrombocytopenic purpura (aTTP) while on the requested medication? Note: A recurrence is when the patient needs to reinitiate plasma exchange. A 28-day extension of therapy does not count as a recurrence.

❒ Yes, *Continue to 3*

❒ No, *Continue to 3*

❒ Unknown, *Continue to 3*

3. Please indicate the clinical setting for which the requested medication will be used. Note: Initial course of the requested medication is treatment with the requested medication during and 30 days after plasma exchange. A recurrence is when the patient needs to reinitiate plasma exchange. A 28-day extension of therapy does not count as a recurrence.

❒ Directly following an initial 30-day course of the requested medication, as an extension of therapy for persistent underlying aTTP., *Continue to 7*

❒ Directly following the completion of plasma exchange in the hospital., *Continue to 4*

4. Did the patient receive the requested medication with plasma exchange?

❒ Yes, *Continue to 5*

❒ No, *Continue to 5*

5. Will the requested medication be given in combination with immunosuppressive therapy?

❒ Yes, *Continue to 6*

❒ No, *Continue to 6*

6. Will the patient receive the requested medication beyond 30 days from the cessation of plasma exchange (excluding when the patient has documented persistent aTTP)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

7. Does the patient have signs of persistent underlying aTTP?

❒ Yes, *Continue to 8*

❒ No, *Continue to 8*

8. What is the patient's ADAMTS13 activity level? ***ACTION REQUIRED***: Attach supporting chart note(s).

❒ Less than 10% ***ACTION REQUIRED****: Submit supporting documentation, Continue to 10*

❒ 10% or greater ***ACTION REQUIRED****: Submit supporting documentation, Continue to 9*

❒ Unknown, *Continue to 9*

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org

9. Does the patient have all of the following: a) Microangiopathic hemolytic anemia (MAHA) documented by the presence of schistocytes on peripheral smear, b) Thrombocytopenia (platelet count below normal per laboratory reference range), and c) Elevated lactate dehydrogenase (LDH) level (LDH level above normal per laboratory reference range)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s).
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Will the requested medication be given in combination with immunosuppressive therapy?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. For this course of treatment, has the patient received a prior 28-day extension of therapy after the initial course of therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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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