JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

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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:** _____

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* ❑ *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

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

Criteria Questions:

1. What is the diagnosis?
   - ❑ Immune thrombocytopenia (ITP)
   - ❑ Hematopoietic syndrome of acute radiation syndrome (acute exposure to myelosuppressive doses of radiation)
   - ❑ Myelodysplastic syndromes
   - ❑ Chemotherapy-induced thrombocytopenia (CIT)
   - ❑ 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

4. Is the requested drug being prescribed by, or in consulation with, a hematologist or oncologist? ❑ Yes ❑ No

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

Section A: Immune Thrombocytopenia (ITP)

5. Is the request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #7*

6. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If No, skip to #10*

7. Has the patient had an inadequate response or is intolerant to corticosteroids, immunoglobulins, or splenectomy? ❑ Yes ❑ No

8. 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 $x10^9$/L ***(circle one)*** ❑ Unknown
   If less than 30,000/mcL (less than $30x10^9$/L), no further questions.

9. 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

10. 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 $x10^9$/L ***(circle one)*** ❑ Unknown
    If greater than or equal to 50,000 to less than or equal to 200,000/mcL ($50x10^9$ to $200x10^9$/L), no further questions.

11. *If greater than 200,000/mcL (greater than $200x10^9$/L) to less than or equal to 400,000/mcL (less than or equal to $400x10^9$/L),* will dosing be reduced to obtain a platelet count sufficient to avoid clinically important bleeding? ❑ Yes ❑ No *No further questions*.

12. *If less than 50,000/mcL (less than $50x10^9$/L)*, is the platelet count sufficient to prevent clinically important bleeding? *If Yes, no further questions.* ❑ Yes ❑ No

13. 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

14. Is the request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #16*

15. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If No, skip to #18*

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16. 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

17. Does the patient have severe or refractory thrombocytopenia following disease progression or no response to hypomethylating agents (such as azacitidine and decitabine), immunosuppressive therapy, or clinical trial? ❑ Yes ❑ No *No further questions*.

18. Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)? ❑ Yes ❑ No

Section C: Chemotherapy-induced Severe Thrombocytopenia

19. Is the request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #23*

20. 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 #22*

21. Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)? ❑ Yes ❑ No

22. What is the current platelet count? ***ACTION REQUIRED: Attach laboratory documentation or chart notes with current platelet count.***
Indicate current results: _____ /mcL or $x10^9$/L ***(circle one)*** ❑ Unknown *No further questions*.

23. Has the patient's platelet count remained less than 100,000/mcL (less than $100x10^9$/L) for at least 3-4 weeks following the last chemotherapy administration? ***Action Required: Attach laboratory documentation or chart notes with current platelet count.*** *If Yes, no further questions* ❑ Yes ❑ No

24. Has chemotherapy administration been delayed related to thrombocytopenia? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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