AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Wayrilz™ (rilzabrutinib)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage: 400 mg by mouth twice daily

Quantity Limit: 2 tablets per day

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Member is ≥ 18 years of age
- ❑ Requesting provider is a hematologist, or has been in consultation with one
- ❑ Member must have a diagnosis of Chronic Immune Thrombocytopenia (ITP), refractory after previous treatment for 6 months or greater

(Continued on next page)

- ❑ Member's condition meets **ONE** of the following:
  - ❑ Documentation of platelet levels within the last 30 days has been submitted confirming < 30 x 10^9/L
  - ❑ Documentation of symptomatic bleeding, or high risk for bleeding, and platelet levels within the last 30 days has been submitted confirming < 50 x 10^9/L
- ❑ Member must have failed a first-line therapy option with a corticosteroid such as prednisone 0.5-2.0 mg/kg per day:

  DRUG/DOSE: _____ Dates of therapy: _____
- ❑ Member's interval treatment history must record **ONE** of the following:
  - ❑ IVIG (accepted if taken in combination with corticosteroids)
  - ❑ Rituximab
  - ❑ Splenectomy
- ❑ Member must have a documented trial and failure (i.e., platelet trend history not reaching target/goal) of therapy with a thrombopoietin (TPO) receptor agonist such as eltrombopag (generic Promacta®), Nplate® (romiplostim), or Doptelet® (avatrombopag) **(will require different prior authorization form)**

Reauthorization: 6 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is **NOT** experiencing unacceptable toxicity from the drug (e.g., diarrhea, liver toxicity, hypertension, neutropenia)
- ❑ Clinical hematology laboratory tests and liver function tests have been monitored regularly and the most recent results are submitted **[laboratory values for platelet count is required to be attached to request (i.e., drawn within the previous 28 days)]**
- ❑ A platelet count of at least 50 × 10^9/L has been achieved and maintained

  [**NOTE:** if platelet count does not increase to sufficient level within the initial authorization period, therapy will not be continued]

Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.**

***Approved by Pharmacy and Therapeutics Committee: 11/20/2025**
REVISED/UPDATED/REFORMATTED: 12/11/2025