

SENTARA HEALTH PLANS

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 1-800-750-9692.** 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 Sentara #: _____ 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
- Member's condition meets **ONE** of the following:
 - Documentation of platelet levels within the last 30 days has been submitted confirming $< 30 \times 10^9/L$
 - Documentation of symptomatic bleeding, or high risk for bleeding, and platelet levels within the last 30 days has been submitted confirming $< 50 \times 10^9/L$

(Continued on next page)

- 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 $50 \times 10^9/L$ 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.****