OPTIMA HEALTH PLAN

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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Mulpleta® (lusutrombopag)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

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.

- ❑ The member has a diagnosis of chronic liver disease

AND

- ❑ The requesting provider is a gastroenterologist or hematologist, or has been in consultation with one

AND

- ❑ The member is scheduled for an invasive procedure
  - ❑ Document invasive procedure date: _____

  NOTE:

  Begin Mulpleta 8-14 days prior to procedure (undergo procedure 2-8 days after the last dose)

AND

- ❑ The member has had an unsuccessful trial of Doptelet®

AND

- ❑ The member has a baseline platelet count of $\leq 55{,}000/\ mm^3$
  - ❑ Document platelet count prior to therapy initiation: _____/ mm^3

AND

- ❑ Quantity Limit: 7 tablets

  Dosage: 1 tablet (3mg) by mouth daily for 7 days

Medication being provided by Specialty Pharmacy - PropriumRx

(Continued on next page; signature page is required to process request.)

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(Please ensure signature page is attached to form.)

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 06/20/2019
REVISED/UPDATED: ~~8/13/2019;~~ **11/12/2019**