

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: (Select drug below)

Doptelet[®] (avatrombopag)

Doptelet[®] Sprinkle (avatrombopag)

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 Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

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

Recommended Dosage and Quantity Limits:

Chronic liver disease and scheduled to undergo a procedure	Chronic immune thrombocytopenia
Platelet count 40,000 to <50,000/mm³ Quantity Limit: 10 tablets Dosage: 2 tablets (40 mg) by mouth daily for 5 days	Patients ≥ 6 years of age Quantity Limit: 2 tablets per day Dosage: 20 mg once daily (Initial Dose Regimen); Maximum of 2 tablets (40 mg) once daily
Platelet count <40,000/mm³ Quantity Limit: 15 tablets Dosage: 3 tablets (60 mg) by mouth daily for 5 days	Patients ≥ 1 year to < 6 years of age Quantity Limit: 2 capsules per day Dosage: 10 mg once daily (Initial Dose Regimen); Maximum of 2 capsules (20 mg) once daily

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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.

Diagnosis: Chronic Liver Disease-Associated Thrombocytopenia

ONE (1) TIME Service/Procedure-Date Approval

- Member has a diagnosis of chronic liver disease

AND

- Member is ≥ 18 years of age

AND

- Requested medication has been prescribed by or in consultation with a gastroenterologist or hematologist

AND

- Member is scheduled for an invasive procedure associated with moderate to high risk for bleeding

[**Moderate Risk:** Liver biopsy, bronchoscopy, Ethanol ablation therapy or chemoembolization for hepatocellular carcinoma]

[**High Risk:** Vascular catheterization (including right-side procedures in patients with pulmonary hypertension), Transjugular intrahepatic portosystemic shunt, Dental procedures, Renal biopsy, Biliary interventions, Nephrostomy tube placement, Radiofrequency ablation, Laparoscopic interventions]

Name of procedure: _____ **Procedure date:** _____

NOTE: Begin Doptelet 10-13 days prior to procedure (undergo procedure 5-8 days after the last dose)

AND

- Member has a baseline platelet count of $\leq 55 \times 10^9/L$

Document platelet count prior to therapy initiation: _____ $\times 10^9/L$

AND

- Select the corresponding dosing regimen for the member:

- Platelet count $40 \times 10^9/L$ to $<50 \times 10^9/L$**

Quantity Limit: 10 tablets

Dosage: 2 tablets (40 mg) by mouth daily for 5 days

- Platelet count $<40 \times 10^9/L$**

Quantity Limit: 15 tablets

Dosage: 3 tablets (60 mg) by mouth daily for 5 days

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Diagnosis: Chronic Immune Thrombocytopenia (ITP)

Initial Authorization: 6 months

- Member has a diagnosis of chronic ITP for at least 6 months (OR meets the corticosteroid requirement below)

AND

- Member is 1 year of age or older

AND

- 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 $< 50 \times 10^9/L$

AND

- Requested medication has been prescribed by or in consultation with a hematologist

AND

- Member must have failed a first-line therapy option with a corticosteroid at a recommended dose of 0.5-2.0 mg/kg prednisone per day (**failure defined as not having a response to at least a 3-month trial or is corticosteroid-dependent**):

DRUG/DOSE: _____ Dates of therapy: _____

AND

- Therapy with Doptelet will be initiated at 10 to 20 mg once daily (depending on the member's age), unless otherwise indicated, **AND** the provider will adhere to established dosing level recommendations based on platelet count [see **dose table(s) in reauthorization section**]

Diagnosis: Chronic Immune Thrombocytopenia ONLY

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's platelet count has not reached target level to recommend discontinuation of therapy

AND

- Document platelet count 2 weeks after therapy initiation: _____ $\times 10^9/L$

AND

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- Document current platelet count [lab work measured within the date of this reauthorization request]:
_____ x10⁹/L

AND

- Based on current platelet count, enter dose level (see tables below) at which therapy will continue:

TABLE 1: DOPTelet Tablets Recommended Dose Adjustments for Adult Patients with Chronic Immune Thrombocytopenia and Pediatric Patients 6 Years and Older with Persistent or Chronic Immune Thrombocytopenia

Platelet Count (x10 ⁹ /L)	Dose Adjustment or Action
Less than 50 after at least 2 weeks of DOPTelet	Increase One Dose Level (according to dose table below) [Wait 2 weeks to assess the effects of this regimen and any subsequent dose adjustments]
Between 200 and 400	Decrease One Dose (according to dose table below) [Wait 2 weeks to assess the effects of this regimen and any subsequent dose adjustments]
Greater than 400	Stop DOPTelet. [Increase platelet monitoring to twice weekly. When platelet count is less than 150 x10 ⁹ /L, decrease One Dose Level (according to dose table below) and reinstate therapy.]
Less than 50 after 4 weeks of DOPTelet 40 mg once daily	Discontinue DOPTelet.
Greater than 400 after 2 weeks of DOPTelet 20 mg weekly	Discontinue DOPTelet.

TABLE 2: DOPTelet Tablet Dose Levels for Titration in Adult Patients with Chronic Immune Thrombocytopenia and Pediatric Patients 6 Years and Older with Persistent or Chronic Immune Thrombocytopenia

Dose	Dose Level
40 mg Once Daily	6
40 mg Three Times a Week AND 20 mg on the Four Remaining Days of Each Week	5
20 mg Once Daily (Initial Dose Regimen)	4
20 mg Three Times a Week	3
20 mg Twice a Week OR 40 mg Once Weekly	2
20 mg Once Weekly	1

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TABLE 3: DOPTELET SPRINKLE Dose Adjustments for Patients 1 Year to Less than 6 Years with Persistent or Chronic Immune Thrombocytopenia

Platelet Count (x10 ⁹ /L)	Dose Adjustment or Action
Less than 50 after at least 2 weeks of DOPTELET SPRINKLE	Increase One Dose Level (according to dose table below) [Wait 2 weeks to assess the effects of this regimen and any subsequent dose adjustments]
Between 200 and 400	Decrease One Dose (according to dose table below) [Wait 2 weeks to assess the effects of this regimen and any subsequent dose adjustments]
Greater than 400	Stop DOPTELET SPRINKLE. [Increase platelet monitoring to twice weekly. When platelet count is less than 150 x10 ⁹ /L, decrease One Dose Level (according to dose table below) and reinstitute therapy.]
Less than 50 after 4 weeks of DOPTELET SPRINKLE 20 mg once daily	Discontinue DOPTELET SPRINKLE.
Greater than 400 after 2 weeks of DOPTELET SPRINKLE 10 mg weekly	Discontinue DOPTELET SPRINKLE.

TABLE 4: DOPTELET SPRINKLE Dose Levels for Titration in Pediatric Patients 1 Year to Less than 6 Years with Persistent or Chronic Immune Thrombocytopenia

Dose	Dose Level
20 mg Once Daily	6
20 mg Three Times a Week AND 10 mg on the Four Remaining Days of Each Week	5
10 mg Once Daily (Initial Dose Regimen)	4
10 mg Three Times a Week	3
10 mg Twice a Week OR 20 mg Once Weekly	2
10 mg Once Weekly	1

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.****