SENTARA COMMUNITY PLAN
(MEDICAID)

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: Mulpleta® (lusutrombopag)

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below **ALL** that apply. TO receive a **SINGLE** treatment course per scheduled procedure approval for this drug, **ALL** criteria **must** be met. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

1. Does the member have a diagnosis of chronic liver disease (CLD)? ❑ Yes ❑ No

AND

2. Is the member 18 years old or older? ❑ Yes ❑ No

AND

3. The member does NOT have Child-Pugh class C liver disease, absence of hepatopetal blood flow, a prothrombotic condition other than CLD or a history of splenectomy, partial splenic embolization, or thrombosis. ❑ Yes ❑ No

AND

(Continued on next page)

4. The member has a platelet count of < 50 x 10^9/L. ❑ Yes ❑ No

AND

5. The member has an invasive procedure scheduled. ❑ Yes ❑ No

AND

6. The member has lusutrombopag scheduled to begin 8 to 14 days prior to the procedure, with the procedure occurring 2 to 8 days following the last dose of lusutrombopag. ❑ Yes ❑ No

AND

7. The member is NOT scheduled for a thoracotomy, laparotomy, open-heart surgery, craniotomy, or organ resection. ❑ Yes ❑ No

Medication being provided by a Specialty Pharmacy – PropriumRx

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.

***REVISED/UPDATED:** ~~2/25/2019~~, **11/09/2023**