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 may be delayed.**

Drug Requested: Doptelet® (avatrombopag)

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:** _____

Recommended Dosage and Quantity Limits:

Chronic liver disease and scheduled to undergo a procedure	Chronic immune thrombocytopenia
Platelet count 40,000 to <50,000/mm^3 Quantity Limit: 10 tablets Dosage: 2 tablets (40mg) by mouth daily for 5 days	20 mg Once Daily (Initial Dose Regimen); MAXIMUM, 2 tablets (40 mg) once daily
Platelet count <40,000/ mm^3 Quantity Limit: 15 tablets Dosage: 3 tablets (60mg) by mouth daily for 5 days	

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

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AND

- ❑ Member is ≥ 18 years of age

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 associated with moderate to high risk for bleeding

  [Moderate Risk: Liver biospsy, 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

- ❑ The member has a baseline platelet count of ≤ 55 $x10^9/L$

  Document platelet count prior to therapy initiation: _____ $x10^9/L$

AND

- ❑ Select the corresponding dosing regimen for the member:
  - ❑ **Platelet count 40 $x10^9/L$ to <50 $x10^9/L$**
    Quantity Limit: 10 tablets
    Dosage: 2 tablets (40mg) by mouth daily for 5 days
  - ❑ **Platelet count <40 $x10^9/L$**
    Quantity Limit: 15 tablets
    Dosage: 3 tablets (60mg) by mouth daily for 5 days

❑ Diagnosis: Chronic Immune Thrombocytopenia (ITP)

Intial Authorization Approval: 6 months

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

AND

- ❑ Member is ≥ 18 years of age

AND

- ❑ Documentation of platelet levels within the last 30 days has been submitted confirming < 30 x $10^9/L$

AND

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

AND

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- ❑ 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

- ❑ Member must have failed **one (1)** of the following therapies: Promacta (eltrombopag) or Nplate (romiplostim) **(will require different prior authorization form)**

AND

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

Reauthorization Approval of Chronic Immune Thrombocytopenia Diagnosis ONLY: 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: _____ **x10^9/L**

AND

- ❑ Document current platelet count [lab work measured within the date of this reauthorization request]: _____ **x10^9/L**

AND

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

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TABLE 1: Dose Adjustment and Corresponding Platelet Count

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 reinitiate 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.**
Platelet Count ($x10^9$/L)	**Dose Adjustment or Action**

TABLE 2: Dosage Adjustment Recommendations

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

Medication being provided by Specialty Pharmacy - PropriumRx

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 pha rmacy paid claims or submitted chart notes.****