

## PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

# **Doptelet**

Fax back to: (833) 605-4407 Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process,

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Patient Name:	Prescriber Name:	
Member Number:	Fax: Phone:	
Date of Birth:	Office Contact:	
Line of Business:   Exchange - PA	NPI: State Lic ID:	
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	
the enrollee or the enrollee's ability to regain maximum function.	certify that the standard review timeframe may seriously jeopardize the life or health of	
Drug Name:		
Strength: Directions / SIG:		
Please attach any pertinent medical history including labs and information for this member that may support approval.  Please answer the following questions and sign.		
Q1. Is this a request for reauthorization?		
☐ Yes	□No	
Q2. Has the patient had a positive clinical respondence complications?	nse and remains at risk for bleeding	
☐ Yes	□ No	
Q3. Does the patient have a diagnosis of thrombocytopenia with chronic liver disease?		
☐ Yes	□No	
Q4. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q5. Is there documentation that baseline platelet count is less than 50,000/mcL?		
☐ Yes	□No	

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Patient Name:	Prescriber Name:	
Q6. Is there documentation showing that the patient is scheduled to undergo a procedure?		
☐ Yes	□ No	
Q7. Is Doptelet being prescribed by or in consultation with a hematologist, hepatologist, or infectious disease specialist?		
□ Yes	□ No	
Q8. Does the patient have a diagnosis of chronic immune thrombocytopenia (ITP) or persistent thrombocytopenia?		
□ Yes	□ No	
Q9. Is there documentation that baseline platelet count is less than 30,000/mcL?		
☐ Yes	□ No	
Q10. Has the patient had an inadequate response, intolerance, or contraindication to one of the following: glucocorticoids (prednisone, dexamethasone, or methylprednisolone), immunoglobulins, or splenectomy?		
☐ Yes	□ No	
Q11. Is the patient 1 year of age or older?		
□ Yes	□ No	
Q12. Is Doptelet being prescribed by or in consultation with a hematologist?		
□Yes	□ No	
Q13. Additional Information:		
Prescriber Signature	Date	

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Patient Name:	Dressviker Neme
	Prescriber Name:

v2025