Jefferson Health Plans

2024 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.

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):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

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. Type of Request:

☐ Initial Request - Go to 2 ☐ Continuation Request - Go to 8

Q2. Will the requested medication be used in combination with other thrombopoietin receptor agonists (e.g., Mulpleta, Promacta, Nplate) or with spleen tyrosine kinase inhibitors (e.g., Tavalisse)?

☐ Yes ☐ No

Q3. What is the diagnosis?

☐ Thrombocytopenia in chronic liver disease – Go to 4 ☐ Chronic immune thrombocytopenia (ITP) – Go to 6

Q4. Does the patient meet both of the following criteria:
A) Patient has an untransfused (pretreatment) platelet count of less than 50x109/L taken within 14 days of the request
B) Patient is scheduled to undergo a procedure?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Is the requested medication being prescribed by or in consultation with a hematologist, hepatologist or gastroenterologist?

☐ Yes ☐ No

Q6. Does the patient meet both of the following criteria:
A) Inadequate response or intolerance to prior therapy (for example, corticosteroids or immunoglobulins);
B) Untransfused (pretreatment) platelet count at any point prior to the initiation of the requested medication is less than 30x109/L OR 30x109/L to 50x109/L with symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma) or risk factors for bleeding?

☐ Yes ☐ No

Q7. Is the requested medication being prescribed by or in consultation with a hematologist?

☐ Yes ☐ No

Q8. For continuation, what is the diagnosis?

☐ Thrombocytopenia in chronic liver disease ☐ Chronic immune thrombocytopenia (ITP)

Q9. For chronic ITP, please select which one the patient meets:

☐ Patients with current platelet count less than 50x109/L for whom the platelet count is not sufficient to prevent clinically important bleeding and who have not received a maximal Doptelet dose for at least 4 weeks

☐ Patients with current platelet count less than 50x109/L for whom the current platelet count is sufficient to prevent clinically important bleeding

☐ Patients with current platelet count of 50x109/L to 200x109/L

☐ Patients with current platelet count greater than 200x109/L to less than or equal to 400x109/L for whom Doptelet dosing will be adjusted to achieve a platelet count sufficient to avoid clinically important bleeding

Q10. Additional Information:

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

2024 Prior Authorization Request