Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

Thrombocytopenic Agents Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ Cablivi (caplacizumab-yhdp)
☐ Doptelet (avatrombopag)
☐ Mulpleta (lusutrombopag)
☐ Nplate (romiplostim)
☐ Promacta (eltrombopag)
☐ Tavalisse (fostamatinib)

Dose and frequency _____ **Duration of therapy** _____

Indication (Check all that apply.)

☐ Acquired thrombotic thrombocytopenic purpura (aTTP)
☐ Chronic, relapsed, or refractory immune thrombocytopenia (ITP)
☐ Severe aplastic anemia
☐ Thrombocytopenia due to chronic liver disease (CLD)
☐ Thrombocytopenia in the setting of hepatitis C

Section I. Please complete for Doptelet and Mulpleta requests for thrombocytopenia due to chronic liver disease.

1. Is a procedure planned?
   ☐ Yes. Please provide anticipated date of procedure. _____ ☐ No
2. Please provide date and results of most recent platelet count (including laboratory reference ranges).
   _____
3. For Mulpleta requests, has the member had a trial with Doptelet?
   ☐ Yes. Please list the dates/duration of use and outcomes below.
   Dates/duration of use _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain why not. _____
   _____

Section II. Please complete for Doptelet, Nplate, Promacta, and Tavalisse requests for chronic, relapsed or refractory ITP.

1. Please provide date and results of most recent platelet count (including laboratory reference ranges). For platelet count > 30,000 cells/mcL, describe medical necessity for platelet elevation.

   _____

   _____

2. Has the member had a trial with a corticosteroid or immunoglobulin therapy?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcomes below.
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.

   _____

   ☐ No. Please explain why not. _____
3. Has the member had a splenectomy? ☐ Yes ☐ No
4. For Doptelet, Nplate, and Tavalisse requests, has the member had a trial with Promacta?
   ☐ Yes. Please list the dates/duration of use and outcomes below.
   Dates/duration of use _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.

   _____

   ☐ No. Please explain why not. _____

Section III. Please complete for Promacta requests for thrombocytopenia in the setting of hepatitis C.

1. Please provide date and results of most recent platelet count (including laboratory reference ranges).

   _____
2. Is the member currently on interferon therapy? ☐ Yes. Please provide start date. _____ ☐ No
3. For members not currently on interferon therapy, does the treatment plan include initiation of therapy with interferon? ☐ Yes ☐ No

Section IV. Please complete for Promacta requests for severe aplastic anemia.

1. Please provide date and results of most recent platelet count (including laboratory reference ranges).

   _____
2. Has the member had a trial with anti-thymocyte globulin (ATG)?
   ☐ Yes. Please list the dates/duration of use and outcomes below.
   Dates/duration of use _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.

   _____

   ☐ No. Please explain why not. _____
3. Has the member had a trial with cyclosporine?
   ☐ Yes. Please list the dates/duration of use and outcomes below.
   Dates/duration of use _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.

   _____

   ☐ No. Please explain why not. _____
4. For use of Promacta in combination with ATG and cyclosporine, please provide clinical rationale.

   _____

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Section V. Please complete for Cablivi requests.

Will the member be taking the requested medication concurrently with immunosuppressive therapy?

☐ Yes. Please list the drug name and dates/duration of use.

Drug name _____ Dates/duration of use _____

☐ No. Please explain why not. _____

Section VI. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____