



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

## 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](http://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

- |  |   |
|--|---|
| <input type="checkbox"/> Cablivi (caplacizumab-yhdp) | <input type="checkbox"/> Nplate (romiplostim)     |
| <input type="checkbox"/> Doptelet (avatrombopag)     | <input type="checkbox"/> Promacta (eltrombopag)   |
| <input type="checkbox"/> Mulpleta (lusutrombopag)    | <input type="checkbox"/> Tavalisse (fostamatinib) |

Dose and frequency \_\_\_\_\_ Duration of therapy \_\_\_\_\_

#### Indication (Check all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> Acquired thrombotic thrombocytopenic purpura (aTTP)            | <input type="checkbox"/> Severe aplastic anemia                              |
| <input type="checkbox"/> Chronic, relapsed, or refractory immune thrombocytopenia (ITP) | <input type="checkbox"/> Thrombocytopenia due to chronic liver disease (CLD) |
|   | <input type="checkbox"/> Thrombocytopenia in the setting of hepatitis C      |

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

- Is a procedure planned?  
 Yes. Please provide anticipated date of procedure. \_\_\_\_\_  No
- Please provide date and results of most recent platelet count (including laboratory reference ranges).  
 \_\_\_\_\_
- For Doptelet requests, has the member had a trial with Mulpleta?  
 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. \_\_\_\_\_

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**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. \_\_\_\_\_

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**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

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**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. \_\_\_\_\_

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**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.

\_\_\_\_\_  
\_\_\_\_\_

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**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*

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**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 \_\_\_\_\_