OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY/MEDICAL 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 is not complete, correct, or legible, the authorization can be delayed.**

Drug Requested: **Doptelet®** (avatrombopag)

DRUG INFORMATION: Complete information below or authorization will be delayed

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

1. Does the member have a diagnosis of chronic liver disease? ❑ Yes ❑ No

AND

2. Is the member 18 years old or older? ❑ Yes ❑ No

AND

3. The member has a platelet count of $< 50 \times 10^9$/L. ❑ Yes ❑ No

AND

4. The member has an invasive procedure scheduled. ❑ Yes ❑ No

AND

5. The member is prescribed a dose according to baseline platelet count (10 tablets per 5 days for platelets $\geq 40 \times 10^9$/L or 15 tablets per 5 days for platelets $< 40 \times 10^9$/L).

AND

6. The member has avatrombopag scheduled to begin 10 to 13 days prior to the procedure, with the procedure occurring 5 to 8 days following the last dose of avatrombopag. ❑ Yes ❑ No

(Continued on next page; signature MUST be included with this request form)

(Signature page MUST be included with this request form)

Medication being provided by a Specialty Pharmacy – PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED: 2/25/2019**