

**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:**                    **Mulpleta<sup>®</sup>** (lusutrombopag)

**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. TO receive a **SINGLE** treatment course per scheduled procedure approval for this drug, **ALL** criteria **must** be met. **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 (CLD)?  Yes  No

**AND**

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

**AND**

3. The member does NOT have Child-Pugh class C liver disease, absence of hepatopetal blood flow, a prothrombotic condition other than CLD or a history of splenectomy, partial splenic embolization, or thrombosis.  Yes  No

**AND**

4. The member has a platelet count of < 50 x 10<sup>9</sup>/L.  Yes  No

**AND**

5. The member has an invasive procedure scheduled.  Yes  No

**AND**

6. The member has lusutrombopag scheduled to begin 8 to 14 days prior to the procedure, with the procedure occurring 2 to 8 days following the last dose of lusutrombopag.  Yes  No

**AND**

7. The member is NOT scheduled for a thoracotomy, laparotomy, open-heart surgery, craniotomy, or organ resection.  Yes  No

(continued on next page; signature **must** be attached 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