Prescriber Criteria Form

Doptelet 2026 PA Fax 2586-A v3 010126.docx
Doptelet (avatrombopag), Doptelet Sprinkle (avatrombopag oral granules)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Doptelet.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of thrombocytopenia associated with chronic liver disease? [If no, then skip to question 5.]	Yes	No
2	Is the patient scheduled to undergo a procedure? [If no, then no further questions.]	Yes	No
3	Prior to the scheduled procedure, is the patient's untransfused platelet count less than 50,000 cells per microliter (mcL)? [If no, then no further questions.]	Yes	No
4	Is the patient 18 years of age or older? [No further questions.]	Yes	No
5	Is the requested drug prescribed for the treatment of thrombocytopenia in a patient with chronic or persistent immune thrombocytopenia (ITP)? [If no, then no further questions.]	Yes	No
6	Is the patient currently receiving therapy with the requested drug? [If no, then skip to question 9.]	Yes	No
7	Did the patient's platelet count respond to the requested drug as evidenced by either of the following: A) the current platelet count is less than or equal to 200,000 cells per microliter (mcL), B) the current platelet count is greater than 200,000 cells per microliter	Yes	No

	(mcL) and less than or equal to 400,000 cells per microliter (mcL) and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding? [If no, then no further questions.]		
8	Is the patient 1 year of age or older? [No further questions.]	Yes	No
9	Has the patient experienced an inadequate treatment response or intolerance to a prior therapy such as corticosteroids or immunoglobulins? [If no, then no further questions.]	Yes	No
10	At any point prior to the initiation of the requested medication, did the patient meet ONE of the following criteria: A) untransfused platelet count less than 30,000 cells per microliter, B) untransfused platelet count 30,000 to 50,000 cells per microliter with symptomatic bleeding or risk factor(s) for bleeding (for example, undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma)? [If no, then no further questions.]	Yes	No
11	Is the patient 1 year of age or older?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____