

Request for Prior Authorization
HEMATOPOIETICS/
CHRONIC ITP
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Thrombocytopenia with chronic liver disease in patients scheduled to undergo a procedure (Doptelet, Mulpleta)

Documentation of the following: 1. Pre-treatment platelet count; and 2. Scheduled dosing prior to procedure; and 3. Therapy completion prior to scheduled procedure; and 4. Platelet count will be obtained before procedure.

Platelet count: _____ Lab Date: _____

Date of scheduled procedure: _____

Date for start of drug treatment: _____

After the last dose, a platelet count will be obtained prior to undergoing the procedure: Yes No

Other Diagnosis: _____

Reason for use of Non-Preferred drug requiring prior approval: _____

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
--	--------------------

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.