Nplate (*romiplostim*)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:

☐ Nplate 125mcg vial ☐ Nplate 250mcg vial ☐ Nplate 500mcg vial
☐ Other (please specify):

Directions for use: Dose and Quantity: Duration of therapy:
J-Code: ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home ☐ Physician's Office
☐ Hospital Outpatient ☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

What is your patient's diagnosis?
☐ Hematopoietic Syndrome of Acute Radiation Syndrome (ARS)
☐ Immune Thrombocytopenia (ITP)
☐ Thrombocytopenia in Myelodysplastic Syndrome (MDS)
☐ Thrombocytopenia, Chemotherapy-Induced
☐ Thrombocytopenia due to Immune Checkpoint Inhibitor Therapy (Examples of checkpoint inhibitors are Keytruda [pembrolizumab intravenous infusion], Opdivo [nivolumab intravenous infusion], Yervoy [ipilimumab intravenous infusion], Tecentriq [atezolizumab intravenous infusion], Bavencio [avelumab intravenous infusion], Imfinzi [durvalumab intravenous infusion] and Libtayo [cemiplimab-rwlc intravenous infusion].
☐ other (please specify):

Clinical Information:

Is this initial therapy or is the patient currently receiving Nplate? If patient has been taking samples, please pick "initial therapy."

☐ Initial Therapy
☐ Currently Receiving Nplate

(if ITP/Chemo/Immune Checkpoint Inhibitor Therapy/MDS, if currently receiving) Is documentation being provided that according to the prescriber, the patient has demonstrated a beneficial clinical response to this medication? Note: A beneficial response can include increased platelet counts, maintenance of platelet counts, and/or a decreased frequency of bleeding episodes. - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied.
☐ Yes ☐ No

(if ITP/MDS, if currently receiving) Does your patient remain at risk for bleeding complications? ☐ Yes ☐ No

(if chemo, if currently receiving) Does your patient continue to receive treatment with chemotherapy? ☐ Yes ☐ No

(if ARS) Has the patient been acutely exposed to myelosuppressive doses of radiation? ☐ Yes ☐ No

(if ITP/MDS, if initial) Is documentation being provided that the patient has a platelet count less than 30 x 10 to the 9th power/L (less than 30,000/mcL)? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

> (if no) Is documentation being provided that the patient has a platelet count less than 50 x 10 to the 9th power/L (less than 50,000/mcL)? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if less than 50k) Is the patient at an increased risk of bleeding (according to the prescriber)? ☐ Yes ☐ No

(if ITP, if initial) Is documentation being provided that the patient has undergone a splenectomy? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

> (if no) Is documentation being provided that the patient has tried at least one other therapy? Note: Examples of therapies are systemic corticosteroids, intravenous immunoglobulin, anti-D immunoglobulin, Promacta (eltrombopag tablets and oral suspension), Tavalisse (fostamatinib tablets), Doptelet (avatrombopag tablets), or rituximab. - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if ITP, if initial) Is this medication prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

(if chemo, if initial) Is documentation being provided that the patient has a platelet count that is less than 100 x 10 to the 9th power/L (less than 100,000/mcL)? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if chemo, if initial) Has the patient had thrombocytopenia at least 3 weeks after the most recent dose of chemotherapy?
☐ Yes ☐ No
(if no) Did the patient experience a delay in chemotherapy administration related to thrombocytopenia? ☐ Yes ☐ No

(if chemo/Immune Checkpoint Inhibitor Therapy/MDS, if initial) Is this medication being prescribed by, or in consultation with, a hematologist or an oncologist? ☐ Yes ☐ No

(if Immune Checkpoint Inhibitor Therapy, initial) Is documentation being provided that the patient tried at least one systemic corticosteroid? Note: Examples of a corticosteroid include methylprednisolone and prednisone. - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if Immune Checkpoint Inhibitor Therapy, initial) Is documentation being provided that the patient has a platelet count that is less than 50 x 10 to the 9th power/L (less than 50,000/mcL)? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if MDS, if initial) What is your patient's Myelodysplastic Syndrome (MDS) risk category?

☐ Very low (IPSS-R score of 1.5 or lower)
☐ Low to Intermediate (IPSS-R score greater than 1.5 up to 4.5)
☐ High to Very high (IPSS-R score above 4.5)
☐ Unknown

Additional Pertinent Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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