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** ☐ Retail pharmacy
☐ Prescriber's office stock (billing on a medical claim form) ☐ Home Health / Home Infusion vendor
☐ Other (please specify): ***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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):

What is your patient's diagnosis?

☐ Hematopoietic Syndrome of Acute Radiation Syndrome
☐ Immune Thrombocytopenia
☐ Thrombocytopenia in Myelodysplastic Syndrome (MDS)
☐ Thrombocytopenia, Chemotherapy-Induced
☐ other (please specify):

Clinical Information:

Is this a new start of therapy or continuation of therapy? If your patient has already begun treatment with drug samples, please choose "new start of therapy".

☐ new start
☐ continued therapy

(if continued therapy) Has your patient had a beneficial response (increased platelet counts, reduction in red blood cell transfusions, hemoglobin increase, and/or absolute neutrophil count increase) to this drug? ☐ Yes ☐ No
(if continued therapy) Is your patient still at risk for bleeding complications? ☐ Yes ☐ No
(if no to either question) Please provide clinical support for the continued use of this drug.
(if continued therapy) Is your patient still receiving treatment with chemotherapy? ☐ Yes ☐ No
(if no) Please provide clinical support for the continued use of Nplate.

(if Hematopoietic Syndrome of Acute Radiation Syndrome) Has the patient been acutely exposed to myelosuppressive doses of radiation? ☐ Yes ☐ No

(if MDS, Immune Thrombocytopenia) Does the patient have a platelet count less than 30 x 10 to the 9th power/L (less than 30,000/mcL)? ☐ Yes ☐ No
(if no) Does the patient have a platelet count less than 50 x 10 to the 9th power/L (less than 50,000/mcL)? ☐ Yes ☐ No
(if yes) Is the patient at an increased risk of bleeding? ☐ Yes ☐ No

(if Immune Thrombocytopenia) Is this drug being prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No
(if Immune Thrombocytopenia) Has the patient undergone splenectomy? ☐ Yes ☐ No
(if no) Has the patient tried and had an inadequate response to ONE of the following:
1. Systemic corticosteroids
2. Intravenous immunoglobulin
3. Anti-D immunoglobulin
4. Promacta (eltrombopag tablets and oral suspension)
5. Tavalisse (fostamatinib tablets)
6. Doptelet (avatrombopag tablets)
7. Rituximab? ☐ Yes ☐ No

(if no) Does your patient have a contraindication per FDA label, significant intolerance, or is NOT a candidate* for ALL of the following:
1. Systemic corticosteroids
2. Intravenous immunoglobulin
3. Anti-D immunoglobulin
4. Promacta (eltrombopag tablets and oral suspension)
5. Tavalisse (fostamatinib tablets)
6. Doptelet (avatrombopag tablets)
7. Rituximab? ☐ Yes ☐ No

Notes: Not a candidate due to being subject to a warning per the prescribing information (labeling), having a disease characteristic, individual clinical factor[s], or other attributes/conditions or is unable to administer and requires this dosage formulation

(if MDS) Does your patient have low-risk to intermediate-risk myelodysplastic syndrome (for example: IPSS-R score above 1.5 to 4.5 points)? ☐ Yes ☐ No
(if MDS) Is this drug being prescribed by, or in consultation with, a hematologist or an oncologist? ☐ Yes ☐ No

(if chemo-induced) Does the patient have a platelet count less than 100 x 10 to the 9th power/L (less than 100,000/mcL)? ☐ Yes ☐ No
(if chemo-induced) Is this drug being prescribed by, or in consultation with, a hematologist or an oncologist? ☐ Yes ☐ No

(if chemo-induced) Did your patient have thrombocytopenia at least 3 weeks after the most recent dose of chemotherapy? ☐ Yes ☐ No
(if no) Has the patient experienced a delay in chemotherapy administration related to thrombocytopenia? ☐ Yes ☐ No

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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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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