

# HEALTHY U MEDICAID

## PRIOR AUTHORIZATION REQUEST FORM

### CABLIVI®

**For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department.**

- For **Medical Pharmacy** please fax requests to: 801-213-1547
- For **Retail Pharmacy** please fax requests to: 385-425-4052

**Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

**Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.**

**Product being requested:**  Cablivi® (caplacizumab-yhdp)

Dosing/Frequency: \_\_\_\_\_

**If the request is for reauthorization, proceed to reauthorization section.**

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of acquired thrombotic thrombocytopenia purpura (aTTP) with ADAMTS13 activity <10%?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the prescriber a hematologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Will Cablivi® be started in a hospital setting in combination with plasma exchange?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Will Cablivi® be used in combination with immunosuppressive therapy (e.g. corticosteroids, rituximab)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Have secondary causes of thrombocytopenia been ruled out (e.g. congenital thrombotic thrombocytopenia purpura, hemolytic uremic syndrome, drug-induced thrombocytopenia)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**REAUTHORIZATION**

1. Is the request for reauthorization of therapy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
2. Does documentation show persistent underlying disease with an ADAMTS13 activity <20%?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member experienced >2 recurrences of aTTP during initial therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Has the member demonstrated a positive response to therapy shown by one of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<ul style="list-style-type: none"> <li>• Clinically significant increase in platelet count (i.e. platelet count is within the normal range)</li> <li>• Reduction in neurological symptoms</li> <li>• Improvement in organ-damage markers (lactate dehydrogenase, cardiac troponin1 and serum creatinine)</li> </ul>			
<p><b>What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.</b></p>			
<p>Additional information:</p>			
<p>Physician Signature:</p>			

**\*\* Failure to submit clinical documentation to support this request will result in a dismissal of the request.\*\***

Policy PHARM-HU-094  
 Origination Date: 01/01/2022  
 Reviewed/Revised Date: 05/17/2023  
 Next Review Date: 05/17/2024  
 Current Effective Date: 06/01/2023

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