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%?	☐	☐	**Please provide documentation**
2. Is the prescriber a hematologist or in consultation with one?	☐	☐	
3. Is the member 18 years of age or older?	☐	☐	
4. Will Cablivi® be started in a hospital setting in combination with plasma exchange?	☐	☐	**Please provide documentation**
5. Will Cablivi® be used in combination with immunosuppressive therapy (e.g. corticosteroids, rituximab)?	☐	☐	**Please provide documentation**
6. Have secondary causes of thrombocytopenia been ruled out (e.g. congenital thrombotic thrombocytopenia purpura, hemolytic uremic syndrome, drug-induced thrombocytopenia)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show persistent underlying disease with an ADAMTS13 activity <20%?	☐	☐	**Please provide documentation**
3. Has the member experienced >2 recurrences of aTTP during initial therapy?	☐	☐	
4. Has the member demonstrated a positive response to therapy shown by one of the following:	☐	☐	**Please provide documentation**

• Clinically significant increase in platelet count (i.e. platelet count is within the normal range) • Reduction in neurological symptoms • Improvement in organ-damage markers (lactate dehydrogenase, cardiac troponin1 and serum creatinine)			

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.
Additional information:
Physician Signature:

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