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
☐ 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/MDS, if currently receiving) Is there documentation of 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. ☐ Yes ☐ No

(if no) Please provide support for continued use.

(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) Which of the following applies to your patient?

☐ Platelet count is less than 30 x 10 to the 9th power/L (less than 30,000/mcL)
☐ Platelet count is less than 50 x 10 to the 9th power/L (less than 50,000/mcL)
☐ None of the above
☐ Unknown

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

(if ITP, if initial) Has the patient undergone a splenectomy? ☐ Yes ☐ No

(if no) The covered alternatives are: other therapies - systemic corticosteroids, intravenous immunoglobulin, anti-D immunoglobulin, Promacta (eltrombopag tablets and oral suspension), Tavalisse (fostamatinib tablets), Doptelet (avatrombopag tablets), or ritixumab. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regard to the covered alternatives?

☐ The patient tried at least one of the other therapies.
☐ Other

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

(if chemo, if initial) Does the patient have a platelet count that is less than 100 x 10 to the 9th power/L (less than 100,000/mcL)? ☐ 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 or unknown) Did the patient experience a delay in chemotherapy administration related to thrombocytopenia? ☐ Yes ☐ No

(if chemo/MDS, if initial) Is this medication being prescribed by, or in consultation with, a hematologist or an oncologist? ☐ 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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