

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM
DUR MEDICATIONS MULPLETA® (Iusutrombopag)
Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

MULPLETA® – to receive a SINGLE treatment course per scheduled procedure approval for this drug, complete the following questions.

1. Does the member have a diagnosis of chronic liver disease (CLD)? **AND**
 Yes No
2. Is the member 18 years old or older? **AND**
 Yes No
3. The member does **NOT** have Child-Pugh class C liver disease, absence of hepatopetal blood flow, a prothrombotic condition other than CLD or a history of splenectomy, partial splenic embolization, or thrombosis. **AND**
 Yes No
4. The member has a platelet count of $< 50 \times 10^9/L$. **AND**
 Yes No
5. The member has an invasive procedure scheduled. **AND**
 Yes No
6. The member has lusutrombopag scheduled to begin 8 to 14 days prior to the procedure, with the procedure occurring 2 to 8 days following the last dose of lusutrombopag. **AND**
 Yes No
7. The member is **NOT** scheduled for a thoracotomy, laparotomy, open-heart surgery, craniotomy, or organ resection.

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.

Submission of documentation does NOT guarantee coverage.