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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION WAYRILZ™ (rilzabrutinib)

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: _____

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

WAYRILZ™ – To obtain a six (6)-months approval for this medication, please complete the following questions.

1. Is the member ≥ 18 years of age?

   ☐ Yes ☐ No

2. Does the member have a diagnosis of persistent (defined as 3 to 12 months) or chronic (defined as lasting for > 12 months) immune (idiopathic) thrombocytopenia (ITP) and ONE of the following:

   - The member has a platelet count ≤ 30 x 10^9/L; **OR**
   - The member has a platelet count > 30 x 10^9/L but < 50 x 10^9/L AND has symptomatic bleeding and/or an increased risk of bleeding?

     ☐ Yes ☐ No

3. Does the member have ONE of the following:

   - The member has tried and had an inadequate response to ONE corticosteroid used for the treatment of ITP; **OR**
   - The member has an intolerance or hypersensitivity to ONE corticosteroid used for the treatment of ITP; **OR**
   - The member has an FDA labeled contraindication to ALL corticosteroids used for the treatment of ITP; **OR**
   - The member has tried and had an inadequate response to a thrombopoietin receptor agonist (e.g., avatrombopag [Doptelet], romiplostim [Nplate], eltrombopag [Promacta]); **OR**
   - The member has tried and had an inadequate response to immunoglobulins (intravenous immunoglobulin [IVIg] or Anti-D); **OR**
   - The member has had an inadequate response to a splenectomy; **OR**
   - The member has tried and had an inadequate response to rituximab?

     ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

4. Does the prescriber attest that the member will NOT use Wayrilz in combination with other kinase inhibitors with similar indications (e.g., fostamatinib [Tavalisse])?

   ☐ Yes ☐ No

For renewal, complete the following questions to receive a 1-year approval:

5. Does the member continue to meet the above criteria (questions 1 through 4)?

   ☐ Yes ☐ No

6. Does the member continue to experience clinical benefit from the requested treatment?

   ☐ Yes ☐ No

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.