Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Doptelet

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this a request for reauthorization for a diagnosis of chronic immune thrombocytopenia (ITP) or persistent thrombocytopenia? If YES, go to question 2. If NO, go to question 3.

☐ Yes ☐ No

Q2. Has the patient had a positive clinical response and remains at risk for bleeding complications? If YES, go to 12.

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of thrombocytopenia with chronic liver disease? If YES, go to 4. If NO, go to 8.

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older? If YES, go to 5.

☐ Yes ☐ No

Q5. Is there documentation that baseline platelet count is less than 50,000/mcL? (Labs must be attached). If YES, go to 6.

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☐ Yes ☐ No

Q6. Is there documentation showing that the patient is scheduled to undergo a procedure? If YES, go to 7.

☐ Yes ☐ No

Q7. Is Doptelet being prescribed by or in consultation with a hematologist, hepatologist, or infectious disease specialist?

☐ Yes ☐ No

Q8. Does the patient have a diagnosis of chronic immune thrombocytopenia (ITP) or persistent thrombocytopenia? If YES, go to 9.

☐ Yes ☐ No

Q9. Is there documentation that baseline platelet count is less than 30,000/mcL? If YES, go to 10.

☐ Yes ☐ No

Q10. Has the patient had an inadequate response, intolerance, or contraindication to one of the following: glucocorticoids (prednisone, dexamethasone, or methylprednisolone), immunoglobulins, or splenectomy? If YES, go to 11.

☐ Yes ☐ No

Q11. Is the patient 1 year of age or older? If YES, go to 12.

☐ Yes ☐ No

Q12. Is Doptelet being prescribed by or in consultation with a hematologist?

☐ Yes ☐ No

Q13. Additional Information:

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

v2026

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