Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Doptelet - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Has the patient had a positive clinical response and remains at risk for bleeding complications?

☐ Yes ☐ No

Q3. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q4. Does the patient have a diagnosis of thrombocytopenia with chronic liver disease? If YES, go to 5. If NO, go to 7.

☐ Yes ☐ No

Q5. Is there documentation that baseline platelet count is less than 50,000/mcL?

☐ Yes ☐ No

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Q6. Is there documentation showing that the patient is scheduled to undergo a procedure? If YES, go to 10.

☐ Yes ☐ No

Q7. Does the patient have a diagnosis of chronic immune thrombocytopenia (ITP)?

☐ Yes ☐ No

Q8. Is there documentation that baseline platelet count is less than 30,000/mcL?

☐ Yes ☐ No

Q9. 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

Q10. Is Doptelet being prescribed by or in consultation with a hematologist, hepatologist, or infectious disease specialist?

☐ Yes ☐ No

Q11. Is Doptelet being prescribed by or in consultation with a hematologist?

☐ Yes ☐ No

Q12. Requested Duration:

☐ 12 months ☐ Other:

Q13. Additional Information:

Prescriber Signature Date

v2025

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