UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Adzynma (apadamtase alfa)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met):

1. Does the patient have a diagnosis of congenital thrombotic thrombocytopenic purpura (cTTP) with ADAMTS13 mutation, as confirmed by genetic testing? ❑ **Yes** ❑ **No**
2. Is the medication being prescribed by or in consultation with a provider specializing in the treatment of cTTP such as hematologist, or oncologist? ❑ **Yes** ❑ **No**
3. Is the medication being prescribed for one of the following:? ❑ **Yes** ❑ **No**
   - ☐ Acute exacerbation
   - ☐ Prophylaxis for symptomatic patients
   - ☐ Prophylaxis for asymptomatic pregnant patients Due date:_____
   - ☐ Single prophylactic dose for patients undergoing a procedure or who are acutely ill and have been hospitalized
4. Does the patient have ADAMTS13 activity of < 10%? ❑ **Yes** ❑ **No**
5. Has the patient tried and failed or has a contraindication to plasma infusions? ❑ **Yes** ❑ **No**
6. Will the provider be adhering to the approved dosing outlined below? ❑ **Yes** ❑ **No**

Indication	Dosing
Acute exacerbation	40 IU/kg on day 1, then 20 IU/kg on day 2, then 15 IU/kg on day 3 and daily until 2 days after recovery
Prophylaxis (non-pregnant)	40 IU/kg once every 2 weeks
Prophylaxis (pregnant)	40 IU/kg once every 2 weeks beginning when pregnancy is confirmed until 6 weeks postpartum. The dose may need to be increased during the third trimester.

Reauthorization Criteria:

1. Has the patient had a reduction in acute exacerbations or subacute events (e.g. thrombocytopenia, increase in lactate dehydrogenase)? ❑ **Yes** ❑ **No**

Initial Authorization for Single Prophylactic Dose: 1 month
Initial Authorization for prophylaxis in pregnancy: Up to six (6) weeks postpartum
Initial Authorization for Acute Exacerbation or Prophylaxis: 6 months

Reauthorization for Acute Exacerbation or Prophylaxis: Up to one (1) year

Note:

- Use appropriate HCPCS code for billing:
  Coverage and Reimbursement code lookup: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date