UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Cablivi (caplacizumab)

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. Is the patient 18 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP)? ❑ **Yes** ❑ **No**
3. Does the provider attest to ruling out secondary causes of thrombocytopenia such as congenital thrombotic thrombocytopenia purpura, hemolytic uremic syndrome, and drug-induced thrombocytopenia? ❑ **Yes** ❑ **No**
4. Is the medication being prescribed by or in consultation with a provider specializing in the treatment of aTTP? ❑ **Yes** ❑ **No**
5. Will the medication be used in combination with plasma exchange and at least one immunosuppressive therapy? ❑ **Yes** ❑ **No**
6. Did the patient have an ADAMTS13 activity of less than 10% upon inpatient admission, or are the laboratory findings unavailable? ❑ **Yes** ❑ **No**
7. Has the medication been administered upon inpatient initiation of plasma exchange therapy? ❑ **Yes** ❑ **No**

Initial Authorization: Up to two (2) months after anticipated start date. Anticipated start date: _____

Reauthorization: None

PROVIDER CERTIFICATION

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

_____ _____

Prescriber's Signature Date