Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Caplacizumab-yhdp (Cablivi®) – Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

Diagnosis Information (please indicate the diagnosis and answer the related questions):

□ Acquired Thrombotic Thromcytopenic Purpura (aTTP)

- Has the diagnosis been confirm by one of the following?

  - Member presents with thrombocytopenia together with microangiopathic hemolytic anemia (MAHA) or thrombotic microangiopathy (TMA) confirmed by red blood cell fragmentation (e.g., schistocytes) on peripheral blood smear?

  Yes or No

  - Member's testing shows ADAMTS13 activity levels of less than 10%? **Yes or No**

□ Other: ____

General Questions:

1. Is the medication prescribed by or in consultation with a hematologist?

   □ Yes □ No ______________________________

2. Is the medication prescribed to be given in combination with plasma exchange and immunosuppressive therapy (such as systemic glucorticosteroids, rituximab)?

   □ Yes □ No ______________________________

3. Will the the medication be discontinued if the member experiences more than 2 recurrences of aTTP, while on treatment with Cablivi?

   □ Yes □ No ______________________________

3. Will the treatment be beyond 30 days per episode?

   □ Yes □ No ______________________________

   -If yes, please send in medical records (such as labs) showing remaining signs of persistent underlying disease (such as suppressed ADAMS13activity levels).

4. How many days will total treatment duration be per episode be beyond the last therapeutic plasma exchange?

   ____

Physician office's signature*________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ____________________

Physician Fax #: _____________________ Pharmacy Name: ___________________________Pharmacy Phone: __________________

****Complete page 2 only for Subsequent/Renewal requests****

Diagnosis Information (please indicate the diagnosis and answer the related questions):

□ Acquired Thrombotic Thromcytopenic Purpura (aTTP)

- Is the medication given in combination with plasma exchange and immunosuppressive therapy (such as systemic glucocorticoids rituximab)? **Yes or No**
- Is the **the** request for a new (different) episode requiring the re-initiation of plasma exchange for the treatment aTTP ? **Yes or No**
- Has the member experienced more than 2 recurrences of aTTP, while on Cablivi? **Yes or No**
- Will treatment be beyond 30 days per episode? **Yes or No**
  - -If yes, please send in medical records (such as labs) showing remaining signs of persistent underlying disease (such as suppressed ADAMS13 activity levels).
- How many days will total treatment be per episode be beyond the last therapeutic plasma exchange? ____

□ Other: ____

Physician office's signature*________________________________ Print Name_______________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**