

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 Thrombocytopenic Purpura (aTTP)
- Has the diagnosis been confirm by one of the following?
 - Member presents with severe thrombocytopenia together with microangiopathic hemolytic anemia (MAHA) 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 glucocorticosteroids, 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

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

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

- Acquired Thrombotic Thrombocytopenic 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