Mulpleta (lusutrombopag) 3mg tablets

Mulpleta Prescription Enrollment Form and Statement of Medical Necessity

Contact Mulpleta Assist
Phone: 732-584-6026
Email: distribution.us@eddingpharm.com

Please sign and email the completed form and required documentation. Asterisk indicates required filed or section

1. Patient Information

First Name _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____ Gender Male ☐ Female ☐

Last 4 digits of SSN _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

SELECT ONE OPTION Ship product to patient's address ☐ Ship product to prescriber's address in Section 3 ☐

2. Prescription Insurance Information

SELECT ONE OPTION Patient HAS insurance ☐ Patient DOES NOT have insurance ☐

If patient has insurance, please complete the informaiton below and include copies of the front and back of insurance card(s)

Insurance Name _____

Policy holder name _____ Member ID# _____

Rx BIN # _____ Group ID# _____

Rx PCN# _____ Insurance phone# _____

3. Prescriber Information

First Name _____ Last Name _____

NPI _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

Practice name _____ Primary office contact (Full name) _____

4. Prescription Information for Mulpleta (Lusutrombopag)

3mg: 7-day supply (7 tablets)- NDC # 85320-551-07 Take 1 tablet by mouth daily for 7 days
Mulpleta is taken for 7 days and should be initiated 8 to 14 days pprior to scheduled procedure date

Notes:

Patient first dosing date for Mulpleta (MM/DD/YYYY _____

Prescriber signature Sign here _____ Date (MM/DD/YYYY) _____ Dispense as Written _____

5. Statement of Medical Necessity

A. Are you prescribing Mulpleta per the Prescribing Information? Yes ☐ No ☐

B. Have you determined that the treatment with Mulpleta is medically necessary for the above named patient? Yes ☐ No ☐

C. Does the patient have chronic liver disease? Yes ☐ No ☐ If yes, diagnosis code (ICD-10) _____

Does the patient have thrombocytopenia? Yes ☐ No ☐ If yes, diagnosis code (ICD-10) _____

Patient's platelet count _____ /μL Test date (MM/DD/YYYY) _____

D. Patient's proceedure type of CPT _____ Patient's procedure date(MM/DD/YYYY) _____

E. Proceduralist name _____ Phone _____

6. Prescriber Authorization

By signing below, I verify that the information being disclosed in this enrollment form is complete and accureate to the best of my knowledge.

Prescriber Signature _____ Date (MM/DD/YYYY) _____

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