Mulpleta® (lusutrombopag) 3 mg tablets

Mulpleta Prescription Enrollment Form and Statement of Medical Necessity

Contact *Mulpleta Assist*™
Phone: 866-556-2451
Fax: 866-204-9252

Please sign and fax the completed form and required documentation. Asterisk indicates required field or section.

1. Patient Information

First name* _____ **Last name*** _____

Date of birth* (MM/DD/YYYY) ____/____/____ **Gender*** ☐ M ☐ F **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 information below and include copies of the front and back of insurance card(s)

Insurance name* _____

Policyholder name* _____ **Member ID #*** _____

Rx BIN #* _____ **Group ID #*** _____

Rx PCN #* _____ **Insurance phone #*** _____

3. Prescriber Information

First name* _____ **Last name*** _____ **NPI*** _____

Address* _____

City* _____ **State*** _____ **ZIP*** _____

Phone* _____ **Ext.** _____ **Fax** _____ **Email** _____

Practice name _____ **Primary office contact** (full name) _____

4. Prescription Information for Mulpleta® (lusutrombopag)

☐ **3 mg:** 7-day supply (7 tablets) **– NDC # 59630-551-07 –** Take 1 tablet by mouth daily for 7 days

Notes: _____

Mulpleta is taken for 7 days and should be initiated 8 to 14 days prior to scheduled procedure date

Patient's 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 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 procedure type or 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 accurate to the best of my knowledge. I understand that ASPN Pharmacies, LLC "ASPN" and associated pharmacies reserve the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. I authorize ASPN and associated pharmacies as my designated agent(s) to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment. Finally, I allow ASPN and associated pharmacies to email me regarding prescription status updates and act as my prior authorization agent in dealing with prescription and medical insurance companies.

Prescriber signature* Sign here ▶ _____ **Date*** (MM/DD/YYYY) ____/____/____

Please fax completed form to *Mulpleta Assist*: 866-204-9252

For Full Prescribing Information, visit Mulpleta.com

SHIONOGI INC.

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