PRIOR AUTHORIZATION REQUEST
Promacta

PATIENT: Name______________________
Address: ______________________
City, State, Zip_____________________
D.O.B. _____________________
Member ID:________________________

Prescriber: Name______________________
Address ______________________
City, State, Zip_____________________
Phone _____________________
Fax _____________________
NPI _____________________

Medication Requested:___________ Qty Requested: ___________

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - ☐ INITIAL ☐please answer question 2 – 10
   - ☐ CONTINUATION ☐ please answer question 11 – 24
2. What is the diagnosis or indication?
   - ☐ Chronic idiopathic thrombocytopenic purpura (ITP) ☐ please answer questions 3 – 5
   - ☐ Hepatitis C with thrombocytopenia ☐ please answer question 6
   - ☐ Severe aplastic anemia ☐ please answer questions 7 - 10
   - ☐ All other indications specify:

3. ☐ Yes ☐ No Has the patient had insufficient response to corticosteroids, immunoglobulins, or splenectomy?
4. ☐ Yes ☐ No Is this medication being used to prevent major bleeding in a patient with a platelet count of LESS THAN 30,000/mm3?
5. ☐ Yes ☐ No Is this medication being used in an attempt to achieve platelet counts in the normal range (150,000- 450,000/mm3)?
6. ☐ Yes ☐ No Does the patient have chronic hepatitis C with baseline thrombocytopenia (platelet count LESS THAN 90,000/mm3) which prevents initiation of interferon-based therapy when interferon is required?
7. ☐ Yes ☐ No Has the patient's diagnosis of severe aplastic anemia been confirmed by bone marrow biopsy showing LESS THAN 25% of normal cellularity?
8. ☐ Yes ☐ No Has the patient's diagnosis of severe aplastic anemia been confirmed by bone marrow biopsy showing LESS THAN 50% of normal cellularity?
9. ☐ Yes ☐ No Dose the patient has at least TWO of the following: absolute neutrophil count less

than 500/mm3, platelet count less than 20,000/mm3, and absolute reticulocyte count less than 40,000/mm3?

10. ☐ Yes ☐ No Is the patient's anemia refractory to a previous first line treatment including hematopoietic cell transplantation or immunosuppressive therapy with a combination of cyclosporine A and antithymocyte globulin (ATG)?
11. ☐ Yes ☐ No Does the patient have a platelet count of GREATER THAN 400,000/mm3?
12. ☐ Yes ☐ No Does the patient have a platelet count of GREATER THAN 200,000/mm3?
13. ☐ Yes ☐ No Is the dose being DECREASED for this patient?
14. What is the diagnosis or indication?
    - ☐ Chronic idiopathic thrombocytopenic purpura (ITP) ☐ please answer questions 15 – 18
    - ☐ Hepatitis C with thrombocytopenia ☐ please answer questions 19 – 22
    - ☐ Severe aplastic anemia ☐ please answer questions 15 – 16 & 23 – 24
    - ☐ All other indications please specify:
15. ☐ Yes ☐ No Has the patient's platelet count increased to GREATER THAN or EQUAL TO 50,000/mm3 while on treatment with the requested medication?
16. ☐ Yes ☐ No Is the CURRENT DOSE of the requested medication being maintained for the patient's treatment regimen?
17. ☐ Yes ☐ No Has the patient completed a 4-week treatment course with the requested medication at a dose of 75mg?
18. ☐ Yes ☐ No Is the dose being INCREASED to 75mg?
19. ☐ Yes ☐ No Has the patient's platelet count increased to GREATER THAN or EQUAL TO 90,000/mm3 while on treatment with the requested medication?
20. Please document the END DATE of the patient's current Peg-INF treatment ______________________
21. ☐ Yes ☐ No Has the patient completed an 8-week treatment course with the requested medication at a maximum dose of 100mg?
22. ☐ Yes ☐ No Is the dose being INCREASED 25mg every 2 weeks until platelets are greater than 90,000/mm3 or to a maximum of 100mg?
23. ☐ Yes ☐ No Has the patient completed a 4-week treatment course with the requested medication at the maximum dose of 150mg or with 50mg increases every 2 weeks?
24. ☐ Yes ☐ No Is the dose being INCREASED 50mg every 2 weeks OR to a maximum of 150mg?

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B Physician Signature

PHYSICIAN SIGNATURE ____________________ DATE ____________

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851