PRIOR AUTHORIZATION REQUEST

Promacta

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 What is the diagnosis or indication?

[] Chronic immune thrombocytopenia (ITP) (If checked, go to 2)

[] Treatment of thrombocytopenia in patients with chronic hepatitis C (If checked, go to 10)

[] Aplastic anemia (If checked, go to 13)

[] Thrombocytopenia in myelodysplastic syndrome (MDS) (If checked, go to 19)

If you have any questions, call: 1-888-258-8250

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	[] Other (If checked, no further questions)		
2	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 3) [] Continuation (If checked, go to 8)		
3	Is the requested medication prescribed by or in consultation with a hematologist? [If no, no further questions.]	Yes	No
4	Has the patient tried one other therapy? [Note: Examples of therapies are systemic corticosteroids, intravenous immunoglobulin, anti-D immunoglobulin, Nplate (romiplostim injection for subcutaneous use), Tavalisse (fostamatinib disodium hexahydrate tablets), Doptelet (avatrombopag tablets), or rituximab.] [If yes, skip to question 6.]	Yes	No
5	Has the patient undergone a splenectomy? [If no, no further questions.]	Yes	No
6	Does the patient have a platelet count of less than 30 x 10^9/L (less than 30,000/microliter)? [If yes, no further questions.]	Yes	No
7	Does the patient have a platelet count of less than 50 x 10^9/L (less than 50,000/microliter) and is at an increased risk of bleeding, according to the prescriber? [No further questions.]	Yes	No
8	Has the patient demonstrated a beneficial clinical response (for example, increased platelet counts), according to the prescriber? [If no, no further questions.]	Yes	No
9	Does the patient remain at risk for bleeding complications? [No further questions.]	Yes	No
10	Is the requested medication prescribed by, or in consultation with, a gastroenterologist, a hepatologist, or a physician that specializes in infectious disease? [If no, no further questions.]	Yes	No
11	Does the patient have a low platelet count at baseline (pretreatment) (for example, less than 75 x 10^9/L [less than 75,000/microliter])? [If no, no further questions.]	Yes	No
12	Will the patient be receiving interferon-based therapy for chronic hepatitis C? [Note: Examples of therapies are pegylated interferon (Pegasys [peginterferon alfa-2a injection], PegIntron [peginterferon alfa-2b injection], Intron A (interferon	Yes	No

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	alfa-2b).] [No further questions.]		
13	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 14) [] Continuation (If checked, go to 18)		
14	Is the requested medication prescribed by or in consultation with a hematologist? [If no, no further questions.]	Yes	No
15	Does the patient have low platelet counts at baseline (pretreatment) (for example, less than 30 x 10^9/L [less than 30,000/microliter])? [If no, no further questions.]	Yes	No
16	Has the patient tried at least one immunosuppressant therapy? [Note: Examples of therapies are cyclosporine, Atgam [lymphocyte immune globulin, anti-thymocyte globulin [equine] sterile solution for intravenous use only], mycophenolate moefetil, sirolimus.] [If yes, no further questions.]	Yes	No
17	Will the patient be using Promacta in combination with standard immunosuppressive therapy? [Note: Examples of therapies are cyclosporine, Atgam (lymphocyte immune globulin, anti-thymocyte globulin [equine] sterile solution for intravenous use only), mycophenolate moefetil, sirolimus.] [No further questions.]	Yes	No
18	Has the patient demonstrated a beneficial clinical response, according to the prescriber? [Note: Examples include increases in platelet counts, reduction in red blood cell transfusions, hemoglobin increase, and/or absolute neutrophil count increase.] [No further questions.]	Yes	No
19	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 20) [] Continuation (If checked, go to 24)		
20	Is the requested medication prescribed by, or in consultation with, a hematologist or oncologist? [If no, no further questions.]	Yes	No
21	Does the patient have a platelet count of less than 30 x 10^9/L (less than 30,000/microliter)? [If yes, skip to question 23.]	Yes	No
22	Does the patient have a platelet count of less than 50 x 10^9/L (less than	Yes	No

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	50,000/microliter) and is at an increased risk of bleeding, according to the prescriber? [If no, no further questions.]		
23	Does the patient have low- to intermediate-risk myelodysplastic syndrome (MDS)? [No further questions.]	Yes	No
24	Has the patient demonstrated a beneficial clinical response (for example, increased platelet counts), according to the prescriber? [If no, no further questions.]	Yes	No
25	Does the patient remain at risk for bleeding complications?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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