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	Is this request for an INITIAL therapy or for a CONTINUATION of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No

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

Version 06.2026

PRIOR AUTHORIZATION REQUEST

4	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? [] Chronic immune thrombocytopenia (ITP) (If checked, go to 8) [] Treatment of thrombocytopenia in patients with chronic hepatitis C (If checked, go to 15) [] Aplastic anemia (If checked, go to 20) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 1 year of age? [If no, no further questions.]	Yes	No
9	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 13.]	Yes	No
10	Has the patient undergone a splenectomy? [If no, no further questions.]	Yes	No
11	Does the patient have a platelet count of less than 30 x 10^9/L (less than 30,000 per microliter)? [If yes, skip to question 13.]	Yes	No
12	Does the patient have a platelet count of less than 50 x 10^9/L (less than 50,000 per microliter) and is at an increased risk of bleeding, according to the prescriber? [If no, no further questions.]	Yes	No
13	Is the requested medication being prescribed by or in consultation with a hematologist? [If no, no further questions.]	Yes	No
14	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [Dose: 25 - 50 mg once daily.] [No further questions.]	Yes	No

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PRIOR AUTHORIZATION REQUEST

15	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
16	Does the patient have a low platelet count at baseline (pretreatment) (for example, less than 75 x 10^9/L [less than 75,000 per microliter])? [If no, no further questions.]	Yes	No
17	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 alfa-2b).] [If no, no further questions.]	Yes	No
18	Is the requested medication being 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
19	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [Dose: 25 - 100 mg once daily.] [No further questions.]	Yes	No
20	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
21	Does the patient have low platelet counts at baseline (pretreatment) (for example, less than 30 x 10^9/L [less than 30,000 per microliter])? [If no, no further questions.]	Yes	No
22	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, skip to question 24.]	Yes	No
23	Will the patient be using the requested medication 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.] [If no, no further questions.]	Yes	No
24	Is the requested medication being prescribed by or in consultation with a hematologist? [If no, no further questions.]	Yes	No
25	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [Dose: Patients 2 - 5 years old: 2.5 mg/kg daily, patients 6 - 11 years old: 75 mg daily, patients greater than or equal to 12 years old: 150 mg daily.]	Yes	No

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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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