

PRIOR AUTHORIZATION REQUEST FORM

PROMACTA®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
		,
Office Phone:	Office Fax:	Office Contact:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested:
Promacta[®] (eltrombopag) tablets,
Promacta[®] (eltrombopag) packets

Dosing/Frequency:___

	If the request is for reauthorization, proceed to reauthorization section					
	Questions	Yes	No	Comments/Notes		
1.	Is this request for an expedited review?					
	By checking the "Yes" box to request an expedited review (24					
	hours), you are certifying that applying the standard review time					
	frame (72 hours) may place the member's life, health, or ability					
	to regain maximum function in serious jeopardy.					
	CHRONIC OR PERSISTENT IMMUNE/IDIOPATHIC THROMBOCYTOPENIA (ITP)					
1.	Does the member have a diagnosis of chronic or persistent (>6			Please provide documentation		
	months) immune/idiopathic thrombocytopenia (ITP)?					
2.	Does documentation show a platelet count < 30,000/mcL?			Please provide documentation		
3.	Is the requesting provider a hematologist or oncologist?					
4.	Has the member had a trial and failure of corticosteroids?			Please provide documentation		
	 Adequate trial is defined as prednisone (0.5 - 2.0 mg/kg/day) 					
	or dexamethasone 40mg once daily for 4 days, may be					
	repeated up to 3 times if inadequate response					
	 Failure is defined as platelet count not increasing to at least 					
	50,000/mcL or continued requirement for steroids after 3					
	months of treatment					
	CHRONIC HEPATITIS C- ASSOCIATED THROMBOCYTOPENIA					
1.	Does the member have a diagnosis Chronic Hepatitis C-			Please provide documentation		
	associated thrombocytopenia?					
2.	Is the requesting provider a gastroenterologist, infectious					
	disease specialist, or a hematologist?					

	he member's platelet count < 75,000/mcL?			Please provide documentation				
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	ronic Hepatitis C, but is unable to initiate therapy or maintain							
	rapy due to the degree of thrombocytopenia?							
SEVERE APLASTIC ANEMIA								
1. Doe	es the member have a confirmed diagnosis of Severe Aplastic							
	emia?							
2. Is th	he requesting provider a hematologist?							
3. Doe	es documentation show bone marrow cellularity less than			Please provide documentation				
25%	% or 25-50% if less than 30% of residual cells are							
herr	natopoietic?							
4. Doe	es documentation show at least two of the following?			Please provide documentation				
	Absolute neutrophil count (ANC) < 500/mL							
				Please provide documentation				
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				Please provide documentation				
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				ΓΟΡΕΝΙΑ (ΙΤΡ)				
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	s severe dysphagia preventing the member from taking solid I medications?							
				Please provide documentation				
	es documentation show the member is unable to swallow or			Please provide documentation				
	· · · ·							
1. Is th	he member less than 8 years of age?							
1. Is th	he member less than 8 years of age?							
1 lo +h		1	1					
	PROMACTA PACKETS FOR SUS	PENSIC	N					
glob	globulin, or cyclophosphamide)?							
	munosuppressive therapy (e.g. cyclosporine, anti-thymocyte							
				Please provide documentation				
	s the member had a 3-month trial and failure of standard			Please provide documentation				
• F	Reticulocyte count < 20,000/mcL							
• [Platelet count < 20,000/mcL							
	-			Please provide documentation				
				Place provide decumentation				
	•							
	•			Please provide documentation				
2. Is th	he requesting provider a hematologist?							
1. Doe		1						
				r lease provide documentation				
	s the member been prescribed interferon for the treatment of			Please provide documentation				
- . 1103	s the member been prescribed interferon for the treatment of			Please provide documentation				
	s the member been prescribed interferon for the treatment of			Please provide documentation				
A Has	•			· ·				

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

** Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

Policy PHARM- 060 Origination Date: 02/13/2018 Reviewed/Revised Date: 05/19/2023 Next Review Date: 05/19/2024 Current Effective Date: 06/01/2023

Confidentiality Notice

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