HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
PROMACTA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department 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:
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
CHRONIC OR PERSISTENT IMMUNE/IDIOPATHIC THROMBOCYTOPENIA (ITP)			
1. Does the member have a diagnosis of chronic or persistent (>6 months) immune/idiopathic thrombocytopenia (ITP)?	☐	☐	**Please provide documentation**
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? • 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	☐	☐	**Please provide documentation**
CHRONIC HEPATITIS C- ASSOCIATED THROMBOCYTOPENIA			
1. Does the member have a diagnosis Chronic Hepatitis C-associated thrombocytopenia?	☐	☐	**Please provide documentation**
2. Is the requesting provider a gastroenterologist, infectious disease specialist, or a hematologist?	☐	☐	
3. Is the member's platelet count < 75,000/mcL?	☐	☐	**Please provide documentation**
4. Has the member been prescribed interferon for the treatment of Chronic Hepatitis C, but is unable to initiate therapy or maintain therapy due to the degree of thrombocytopenia?	☐	☐	**Please provide documentation**

SEVERE APLASTIC ANEMIA			
1. Does the member have a confirmed diagnosis of Severe Aplastic Anemia?	☐	☐	
2. Is the requesting provider a hematologist?	☐	☐	
3. Does documentation show bone marrow cellularity less than 25% or 25-50% if less than 30% of residual cells are hematopoietic?	☐	☐	**Please provide documentation**
4. Does documentation show at least two of the following? • Absolute neutrophil count (ANC) < 500/mL • Platelet count < 20,000/mcL • Reticulocyte count < 20,000/mcL	☐	☐	**Please provide documentation**
5. Has the member had a 3-month trial and failure of standard immunosuppressive therapy (e.g. cyclosporine, anti-thymocyte globulin, or cyclophosphamide)?	☐	☐	**Please provide documentation**
PROMACTA PACKETS FOR SUSPENSION			
1. Is the member less than 8 years of age?	☐	☐	
2. Does documentation show the member is unable to swallow or has severe dysphagia preventing the member from taking solid oral medications?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
CHRONIC OR PERSISTENT IMMUNE/IDIOPATHIC THROMBOCYTOPENIA (ITP)			
1. Is the request for reauthorization of therapy for ITP?	☐	☐	
2. Has the member responded to therapy, defined as a platelet count of at least 50,000/mcL?	☐	☐	**Please provide documentation**
CHRONIC HEPATITIS C- ASSOCIATED WITH THROMBOCYTOPENIA			
1. Is the request for reauthorization of therapy for Chronic Hepatitis C-associated with thrombocytopenia?			
2. Has the member responded to treatment, defined as normalization in platelet count and the member continues on interferon therapy for the treatment of chronic hepatitis C?	☐	☐	**Please provide documentation**
SEVERE APLASTIC ANEMIA			
1. Is the request for reauthorization of therapy for severe aplastic anemia?	☐	☐	
2. Has the member responded to therapy, defined as at least one of the following? • Platelet increase of at least 20,000/mcL above baseline • Transfusion independent and stable platelet counts for at least 8 weeks • Hemoglobin increase by at least 1.5g/dL • Reduction in red blood cell transfusions of at least 4 units for at least 8 weeks • Absolute neutrophil count increase of 100% or increase of at least 500/mcL	☐	☐	**Please provide documentation**
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:

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Policy: PHARM-CHIP-060
Origination Date: 07/01/2024
Reviewed/Revised Date: 07/29/2024
Next Review Date: 07/29/2025
Current Effective Date: 08/01/2024