## **HEALTHY U** CHIP

## PRIOR AUTHORIZATION REQUEST FORM **NPLATE®**

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request. If you have medical pharmacy prior authorization questions, please call for assistance: 833-434-4300 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:** □ Nplate (romiplostim) Dosing/Frequency: \_\_ If the request is for reauthorization, proceed to reauthorization section. Yes Questions No **Comments/Notes** CHRONIC OR PERSISTENT IMMUNE/IDIOPATHIC THROMBOCYTOPENIA (ITP) 1. Does documentation show a diagnosis of chronic or persistent Please provide documentation immune/idiopathic thrombocytopenia (ITP)?  $\Box$ 2. Is the request made by a hematologist or oncologist? П 3. Does documentation show the member's platelet count is less Please provide documentation than 30,000/mcL? 4. Has the member had an adequate trial and failure with Please provide documentation corticosteroids, unless contraindicated? Adequate trial defined as prednisone (0.5 - 2.0 mg/kg/day) or dexamethasone (40 mg/day); may be repeated up to 3 times if inadequate response • Failure defined as platelet count not increasing to at least 50,000/mcL or continued requirement for steroids after 3 months of treatment HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME (HS-ARS) 1. Does documentation show diagnosis of acute radiation Please provide documentation syndrome (HS-ARS) with confirmed or suspected exposure to radiation levels greater than 2 Grays (Gy)? **REAUTHORIZATION** CHRONIC OR PERSISTENT IMMUNE/IDIOPATHIC THROMBOCYTOPENIA (ITP) Is the request for reauthorization of ITP therapy?

<ol><li>Is there documentation of recent platelet count of 30,000- 150,000/mcL?</li></ol>			Please provide documentation
3. Does documentation show the medication is providing a clinical benefit for the member?			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 Signature:			
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Policy: PHARM-CHIP-M045 Origination Date: 07/01/2024 Reviewed/Revised Date: 01/29/2025 Next Review Date: 01/29/2026 Current Effective Date: 02/01/2025

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