

HEALTH CHOICE

UTAH

PRIOR AUTHORIZATION REQUEST FORM PROMACTA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah 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)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Does documentation show a platelet count < 30,000/mcL?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is the requesting provider a hematologist or oncologist?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Has the member had a trial and failure of corticosteroids? <ul style="list-style-type: none"> • 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 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
CHRONIC HEPATITIS C- ASSOCIATED THROMBOCYTOPENIA			
1. Does the member have a diagnosis Chronic Hepatitis C-associated thrombocytopenia?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the requesting provider a gastroenterologist, infectious disease specialist, or a hematologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member's platelet count < 75,000/mcL?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

SEVERE APLASTIC ANEMIA			
1. Does the member have a confirmed diagnosis of Severe Aplastic Anemia?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a hematologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does documentation show bone marrow cellularity less than 25% or 25-50% if less than 30% of residual cells are hematopoietic?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does documentation show at least two of the following? <ul style="list-style-type: none"> • Absolute neutrophil count (ANC) < 500/mL • Platelet count < 20,000/mcL • Reticulocyte count < 20,000/mcL 	<input type="checkbox"/>	<input type="checkbox"/>	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)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
PROMACTA PACKETS FOR SUSPENSION			
1. Is the member less than 8 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show the member is unable to swallow or has severe dysphagia preventing the member from taking solid oral medications?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
CHRONIC OR PERSISTENT IMMUNE/IDIOPATHIC THROMBOCYTOPENIA (ITP)			
1. Is the request for reauthorization of therapy for ITP?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member responded to therapy, defined as a platelet count of at least 50,000/mcL?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
SEVERE APLASTIC ANEMIA			
1. Is the request for reauthorization of therapy for severe aplastic anemia?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member responded to therapy, defined as at least one of the following? <ul style="list-style-type: none"> • 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 	<input type="checkbox"/>	<input type="checkbox"/>	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-HCU-060
Origination Date: 01/01/2022
Reviewed/Revised Date: 07/29/2024
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