HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
NPLATE®

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

If you have prior authorization questions, please call Advantage U for assistance: 888-605-0858

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.

Questions	Yes	No	Comments/Notes
CHRONIC OR PERSISTENT IMMUNE/ IDIOPATHIC THROMBOCYTOPENIA (ITP)			
1. Does documentation show a diagnosis of chronic or persistent immune/idiopathic thrombocytopenia (ITP)?	☐	☐	**Please provide documentation**
2. Is the request made by a hematologist or oncologist?	☐	☐	
3. Does documentation show the member's platelet count is less than 30,000/mcL?	☐	☐	**Please provide documentation**
4. Has the member had an adequate trial and failure with 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	☐	☐	**Please provide documentation**
HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME (HS-ARS)			
1. Does documentation show diagnosis of acute radiation syndrome (HS-ARS) with confirmed or suspected exposure to radiation levels greater than 2 Grays (Gy)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
CHRONIC OR PERSISTENT IMMUNE/ IDIOPATHIC THROMBOCYTOPENIA (ITP)			
1. Is the request for reauthorization of ITP therapy?	☐	☐	
2. Is there documentation of recent platelet count of 30,000-150,000/mcL?	☐	☐	**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:

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

Policy: PHARM-MA-M045
Origination Date: 05/04/2023
Reviewed/Revised Date: 05/19/2023
Next Review Date: 05/19/2024
Current Effective Date: 06/01/2023