Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Eltrombopag

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is there confirmation that liver function is being monitored before and during therapy (are labs attached)?

☐ Yes ☐ No

Q2. Does the patient have the diagnosis of thrombocytopenia in a patient with chronic immune thrombocytopenia (ITP)?

☐ Yes ☐ No

Q3. Is the patient 1 year of age or older?

☐ Yes ☐ No

Q4. Has the patient had an inadequate response, intolerance or contraindication to glucocorticoids (prednisone, dexamethasone, or methylprednisolone), immunoglobulins, or splenectomy?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Does the patient have the diagnosis of thrombocytopenia in a patient with chronic hepatitis C?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Has the patient's degree of thrombocytopenia prevented the initiation of interferon-based therapy or limited the ability to maintain interferon-based therapy?

☐ Yes ☐ No

Q8. Does the patient have the diagnosis of severe aplastic anemia?

☐ Yes ☐ No

Q9. Is the patient 2 years of age or older?

☐ Yes ☐ No

Q10. Has the patient had an inadequate response, intolerance or contraindication to immunosuppressive therapy, or will Promacta be used in combination with standard immunosuppressive therapy?

☐ Yes ☐ No

Q11. Is eltrombopag being prescribed by or in consultation with a hematologist?

☐ Yes ☐ No

Q12. Is eltrombopag being prescribed by or in consultation with a hematologist, hepatologist, or infectious disease specialist?

☐ Yes ☐ No

Q13. Is the request for a non-formulary product?

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☐ Yes	☐ No
Q14. For non-formulary products: Is there documentation of inadequate response, intolerance, or contraindication to all formulary eltrombopag products that would not be expected to occur with the requested agent?	
☐ Yes	☐ No
Q15. Additional Information:	

Prescriber Signature _____ Date _____

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