

Thrombopoietics
Phone: 215-991-4300
Fax back to: 866-240-3712

Health Partners 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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	PA PROMISE ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):	
Drug Name:	Strength:	
Quantity:	Refills:	
Directions:		
Diagnosis Code:	Diagnosis:	
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>		

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. The request is for a Thrombopoietic that was previously approved. If YES, go to 8.

Yes

No

Q2. The member meets BOTH of the following:

- Is prescribed the Thrombopoietic for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication
- Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Is prescribed the Thrombopoietic by or in consultation with an appropriate specialist (i.e., hematologist/oncologist, gastroenterologist, hepatologist, etc.)

Q3. For treatment of thrombocytopenia prior to a procedure, both of the following:

- Has a pretreatment platelet count <50 x 10⁹/L
- Will begin treatment with the requested Thrombopoietic prior to the scheduled procedure in accordance with FDA-approved package labeling

Q4. For treatment of severe aplastic anemia, has marrow cellularity <25% (or 25%-50% with <30% residual haematopoietic cells).

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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q5. The member meets TWO of the following:	
<input type="checkbox"/> Neutrophil count <0.5 109/L <input type="checkbox"/> Platelet count <20 109/L <input type="checkbox"/> Reticulocyte count <60 109/L (using an automated reticulocyte count)	
Q6. For treatment of other indications, ONE of the following:	
<input type="checkbox"/> Has a pretreatment platelet count <30 x 109/L	<input type="checkbox"/> Use is supported by the NCCN Drugs & Biologics Compendium, nationally recognized compendia, or peer-reviewed medical literature
Q7. Has documentation of baseline lab results and monitoring as recommended in the FDA-approved package labeling.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. For a non-preferred Thrombopoietic, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Thrombopoietics approved or medically accepted for the beneficiary's indication. See the Preferred Drug List for the list of preferred Thrombopoietics at: https://papdl.com/preferred-drug-list.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. The member meets BOTH of the following:	
<input type="checkbox"/> Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature	<input type="checkbox"/> Is prescribed the Thrombopoietic by or in consultation with an appropriate specialist (i.e., hematologist/oncologist, gastroenterologist, hepatologist, etc.)
Q10. The member meets ONE of the following:	
<input type="checkbox"/> For treatment of severe aplastic anemia, has documentation of a positive clinical response	<input type="checkbox"/> For treatment of all other diagnoses, has an increased platelet count sufficient to avoid bleeding that requires medical attention



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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Member Name:

Prescriber Name:

Q11. Has documentation of repeat lab results and monitoring as recommended in the FDA-approved package labeling.

Yes

No

Q12. Additional Information:

Prescriber Signature

Date

v2026