



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Promacta

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.

Form with fields for Patient Name, HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Prescriber Name, Fax, Phone, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, Specialty/facility name (if applicable).

Expedited/Urgent checkbox

Drug Name:

Strength:

Days Supply:

Number of Refills:

Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 the patient 1 year or older and currently has clinically documented chronic (greater than 3 months) immune (idiopathic) thrombocytopenic purpura (ITP)?

Yes checkbox

No checkbox

Q2. Is the patient at risk of spontaneous bleeding as demonstrated in chart notes by either one of the following? (Please attach chart notes for review) A. Platelet count less than 20 x 109/L OR B. Platelet count less than 30 x 109/L accompanied by symptoms of bleeding

Yes checkbox

No checkbox

Q3. Is the prescribing physician a Hematologist or in consultation with a Hematologist?

Yes checkbox

No checkbox

Q4. Has the patient had an insufficient response to or intolerance to glucocorticoids (prednisone, high-dosed dexamethasone and high-dosed methylprednisolone), intravenous immunoglobulins (IVIg), or anti-D immunoglobulin (anti-D) (anti-D is not appropriate for Rh- member and member who have had splenectomy)?

Yes checkbox

No checkbox

Q5. Has the patient failed to respond to or have a contraindication to splenectomy and rituximab or more potent immunosuppressive agents (such as azathioprine, cyclosporine, cyclophosphamide, danazol, mycophenolate mofetil)?

Yes checkbox

No checkbox

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Promacta

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.

Patient Name:

Prescriber Name:

Q6. Does the patient have complete blood counts (CBCs), including platelet counts, peripheral blood smears, liver function tests and ophthalmic exam? Labs must be attached.

Yes checkbox

No checkbox

Q7. Is the patient over the age of 18 with clinically severe aplastic anemia?

Yes checkbox

No checkbox

Q8. Does the patient have clinically documented severe Aplastic Anemia (supported by one of the following)? a. A bone marrow biopsy showing <25 percent of normal cellularity b. A bone marrow biopsy showing <50 percent normal cellularity in which fewer than 30 percent of the cells are hematopoietic and at least two of the following are present: absolute reticulocyte count <40,000/microL; absolute neutrophil count (ANC) <500/microL; or platelet count <20,000/microL.

Yes checkbox

No checkbox

Q9. Has the patient had an insufficient response to immunosuppressive therapy?

Yes checkbox

No checkbox

Q10. Is the prescribing physician a Hematologist or in consultation with a Hematologist?

Yes checkbox

No checkbox

Q11. Does the patient have complete blood counts (CBCs) with differential, including platelet counts, liver function tests and ophthalmic exam? Labs must be attached.

Yes checkbox

No checkbox

Q12. Is the patient over the age of 18 with documentation of thrombocytopenia with chronic hepatitis C?

Yes checkbox

No checkbox

Q13. Is the prescribing physician a Hematologist or Hepatologist or in consultation with a Hematologist or Hepatologist?

Yes checkbox

No checkbox

Q14. Does the patient have a diagnosis of chronic hepatitis C?

Yes checkbox

No checkbox

Q15. Have the following lab results attached? a. Serum alanine aminotransferase (ALT) b. Serum aspartate aminotransferase (AST) c. Serum bilirubin d. CBC with differentials (including platelet counts) e. HCV RNA

Yes checkbox

No checkbox

Q16. Does the patient have a platelet count of less than 75,000/uL?

Yes checkbox

No checkbox



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Promacta

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.

Patient Name:

Prescriber Name:

Q17. Does the patient have a hemoglobin concentration of greater or equal to 11 g/dL (for men) or greater or equal to 10 g/dL (for women)?

Yes checkbox

No checkbox

Q18. Does the patient have a creatinine clearance of greater or equal to 50 mL/minute?

Yes checkbox

No checkbox

Q19. Does the patient have an absolute neutrophil count (ANC) of greater or equal to 750/mm3?

Yes checkbox

No checkbox

Q20. Does the patient have evidence of decompensated liver disease with Child-Pugh score > 6 (class B and C), history of ascites, or hepatic encephalopathy?

Yes checkbox

No checkbox

Q21. Has the patient experienced a previous course of Peginterferon/ribavirin treatment with failure to achieve a SVR (sustained virological response) for reasons other than thrombocytopenia, despite an optimal course of combination therapy?

Yes checkbox

No checkbox

Q22. Does the patient have evidence of portal vein thrombosis on abnormal imaging within the past 3 months?

Yes checkbox

No checkbox

Q23. Does the patient have history of one of the following conditions? a. Arterial or venous thrombosis b. Hereditary thrombophilic disorders c. Hormone replacement therapy d. Systemic contraception therapy (containing estrogen) e. Smoking f. Diabetes g. Hypercholesterolemia h. Medication for hypertension i. Cancer j. Any disease condition associated with active bleeding or requiring anticoagulation with heparin or warfarin k. History of platelet clumping that would prevent reliable measurement of platelet counts

Yes checkbox

No checkbox

Q24. Is Promacta® being used to normalize platelet counts?

Yes checkbox

No checkbox

Q25. Will the patient's degree of thrombocytopenia prevent the initiation of interferon-based therapy or limits the ability to maintain interferon-based therapy?

Yes checkbox

No checkbox

Q26. Will the patient be treated with Peg interferon/ribavirin in combination with a direct acting antiviral agent?

Yes checkbox

No checkbox

Q27. Will the patient's ALT, AST and serum bilirubin be evaluated during therapy?

Yes checkbox

No checkbox

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Promacta

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.

Patient Name:

Prescriber Name:

Q28. Does the prescriber use the lowest dose of Promacta® to achieve and maintain a platelet count necessary to initiate and maintain antiviral therapy with pegylated interferon and ribavirin?

Yes checkbox

No checkbox

Q29. Will the dose of Promacta® be adjusted every 2 weeks as necessary to achieve the target platelet count (greater than or equal to 90,000/µL) required to initiate antiviral therapy?

Yes checkbox

No checkbox

Q30. Will the CBC with differentials including platelet counts be monitored every week prior to starting antiviral therapy?

Yes checkbox

No checkbox

Q31. Requested Duration:

1 Month checkbox

Q32. Additional Information:

Prescriber Signature

Date

Updated 2018