Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: **Specialty/facility name (if applicable):**	

□ Expedited/Urgent

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 ☐ No

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 ☐ No

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

☐ Yes ☐ No

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 ☐ No

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 ☐ No

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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 ☐ No

Q7. Is the patient over the age of 2 with clinically severe aplastic anemia?

☐ Yes ☐ No

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 ☐ No

Q9. Has the patient had an insufficient response to immunosuppressive therapy or will Promacta be used in combination with immunosuppressive therapy?

☐ Yes ☐ No

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

☐ Yes ☐ No

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 ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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 ☐ No

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Patient Name:	**Prescriber Name:**

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

☐ Yes ☐ No

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 ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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 ☐ No

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 ☐ No

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

☐ Yes ☐ No

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 ☐ No

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

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

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 ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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 ☐ No

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 ☐ No

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

☐ Yes ☐ No

Q31. Requested Duration:

☐ 1 Month

Q32. Additional Information:

Prescriber Signature _____ Date _____

Updated 2018