



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, Strength, Refills, Specialty Pharmacy.

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 this a request for continuation of therapy with the requested product? [If NO, skip to 13.]

Yes No

Q2. Is the requested product prescribed for thrombocytopenia in a patient scheduled to undergo a procedure that was previously approved?

Yes No

Q3. Is this request for Doptelet (avatrombopag) or Mulpleta (lusutrombopag) [If YES, skip to 14.]

Yes No

Q4. Is the requested product prescribed by or in consultation with an appropriate specialist (i.e., hematologist/oncologist, gastroenterologist, hepatologist, etc.)?

Yes No

Q5. Is the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

Q6. Has the patient had a documented increase in platelet count sufficient to avoid bleeding that requires medical attention?

Yes No

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|               |                  |
|---------------|------------------|
| Patient Name: | Prescriber Name: |
|---------------|------------------|

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| <p>Q7. Is this request for the treatment of severe aplastic anemia?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>Q8. Is there documentation of a positive clinical response to the requested product?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>Q9. Is there documentation of repeat lab results and monitoring as recommended in the Food and Drug Administration (FDA)-approved package labeling?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>                         |
| <p>Q10. Is this request for Tavalisse (fostamatinib)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>Q11. Does the patient have diarrhea that is greater than or equal to grade 3?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |
| <p>Q12. Is there a documented plan to manage the diarrhea that is consistent with Food and Drug Administration (FDA)-approved package labeling?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>                                |
| <p>Q13. Is this request for Doptelet (avatrombopag), Mulpleta (lusutrombopag), or Tavalisse (fostamatinib)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>Q14. Does the patient have documented therapeutic failure, contraindication, or intolerance to the preferred thrombopoietics approved for the patient's indication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>         |
| <p>Q15. Is this request for Nplate (romiplostim) or Promacta (eltrombopag)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>Q16. Is the requested product prescribed by or in consultation with an appropriate specialist (i.e., hematologist/oncologist, gastroenterologist, hepatologist, etc.)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>      |
| <p>Q17. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>Q18. Is the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?</p>                                     |

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Patient Name: Prescriber Name:

Form containing questions Q19-Q27 regarding drug documentation, treatment timing, and platelet counts.

Prescriber Signature

Date

Updated for 2022