

## Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

### Nplate (romiplostim) and Promacta (etrombopag) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Nplate  Promacta

Place of administration:

Self-administered

Provider's Office

Outpatient Infusion Center

Name of center: \_\_\_\_\_

Home Infusion

Name of agency: \_\_\_\_\_

Billing options:

Physician buy and bill

Preferred Specialty Vendor

Other: \_\_\_\_\_

### Priority Health Precertification Requirements:

Authorization of Nplate or Promacta requires:

Thrombopoietin receptor agonist criteria:

- Chronic immune (idiopathic) thrombocytopenic purpura (ITP) patients who have had an insufficient response to corticosteroids, immunoglobulins or splenectomy.
- Treatment-limiting adverse drug reaction to corticosteroids or immunoglobulins.
- Current platelet count  $< 50 \times 10^9/L$  with clinical risk of bleeding.

One of the following indications must apply:

Date of chronic ITP diagnosis \_\_\_\_\_

Date and results of last platelet count \_\_\_\_\_

Previous therapy and results:

Corticosteroid name(s), dose, and duration \_\_\_\_\_

Platelet response (with dates): \_\_\_\_\_

Immunoglobulin product name, dose, and durations: \_\_\_\_\_

Platelet response (with dates): \_\_\_\_\_

Treatment-limiting ADR (Description and date): \_\_\_\_\_

**Dose:**

**Nplate:** Starting Dose 1 mcg/kg SC weekly. Median dose to achieve response: 2-3 mcg/kg weekly. (Max dose 10 mcg/kg weekly). Dose to achieve platelet count above  $50 \times 10^9/L$  (not to normal platelet levels). See table below for dose adjustments.

**Promacta:** Starting dose 50 mg QD (25 mg QD if severe hepatic insufficiency). Median dose 50mg QD (Max. 75mg QD). Dose to achieve platelet count above  $50 \times 10^9/L$  (not to normal platelet levels). Monitor Liver function tests, CBC and platelet counts. Discontinue if ALT  $\geq 3 \times$  upper limit of normal and are progressive, are persistent for 4 weeks, are accompanied by increased direct bilirubin or are accompanied by signs or symptoms of hepatic decompensation. See table below for dose adjustments.

**Dosage Adjustment based on Platelet Response:**

Platelet Response	Nplate	Promacta
Starting Dose	1 mcg/kg SC weekly	50 mg QD (25mg if severe hepatic insufficiency)
$< 50 \times 10^9/L$	Increase dose by 1 mcg/kg/week	Increase daily dose by 25 mg to a maximum of 75 mg/day.
$\geq 200 \times 10^9/L$	Reduce dose by 1 mcg/kg/week	
$\geq 200 \times 10^9/L$ to $\leq 400 \times 10^9/L$ for 2 consecutive weeks.		Decrease the daily dose by 25 mg. Wait 2 weeks to assess the effects of this and any subsequent dose adjustments.
$> 400 \times 10^9/L$	If platelet count is $> 400 \times 10^9/L$ , do not dose. Continue to assess the platelet count weekly. After the platelet count has fallen to $< 200 \times 10^9/L$ , resume Nplate at a dose reduced by 1 mcg/kg.	Stop Promacta; increase the frequency of platelet monitoring to twice weekly. Once the platelet count is $< 150 \times 10^9/L$ , reinstate therapy at a daily dose reduced by 25 mg.
$> 400 \times 10^9/L$ after 2 weeks of therapy at lowest dose.		Permanently discontinue Promacta.
Maximum Dose-No Response	Max dose 10 mcg/kg Discontinue if no response in 4 weeks	Max dose 75 mg QD Discontinue if no response in 4 weeks.

**PHYSICIAN STATEMENT**

**For Medicare only:** If none of the above is applicable to this member, please check which, if any, of the following apply:

**If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:**

1.  All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2.  The number of doses available under a dose restriction for the prescription drug:
  - a.  Has been ineffective in the treatment of the enrollee's disease or medical condition, or
  - b.  Based on sound clinical evidence and medical and scientific evidence, the known

relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

3.  The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
- a.  Has been ineffective in the treatment of the enrollee's disease or medical condition, or
  - b.  Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
  - c.  Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4.  None of the above apply

**\*\*If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

**\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*  
Please fax this request to: (877)974-4411 toll free or (616)942-8206  
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**