PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial** ☒ **Commercial Individual (PPACA)** ☐ **Medicaid**
This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. The standard review time averages between 1 and 3 business days.

Nplate® (romiplostim)

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

Drug product:
☐ Nplate® 250 mcg injection
☐ Nplate® 500 mcg injection

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Place of administration:
☐ Provider's office
☐ Outpatient infusion center
☐ Home infusion

Center name: _____
Agency name: _____

Billing:
☐ Physician buy and bill
☐ Preferred specialty vendor
☐ Other: _____

☐ New request
☐ Continuation request

ICD code(s): _____

Precertification Requirements

Patient must meet one of the following 2 criteria:

1) Diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP) with
   a) platelet count <30,000/microL, AND
   b) significant bleeding symptoms
2) Diagnosis of severe, persistent or recurrent ITP with
   a) platelet count <20,000/microL, AND
   b) an insufficient response to corticosteroids, immunoglobulin, or splenectomy, OR
   c) patient is not a candidate for splenectomy or immunoglobulin therapy

(Initial approval is 3 months then annually.)

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 05/2021
Last reviewed 05/2021

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- ☐ chronic ITP
- ☐ Other, the patient's condition is: _____

B. What date was the patient diagnosed with chronic ITP? _____

C. Provide the results of the patient's most recent platelet count:

Date: _____
Platelet count: _____

D. Which of the following treatments were used for the patient's chronic ITP, and what was the patient's platelet response?

- ☐ Splenectomy

- ☐ Corticosteroids

  - Plate response (include dates of labs): _____
  - What treatment-limiting ADR occurred (provide a description and the date of the reaction): _____

- ☐ Immunoglobulin

  - What immunoglobulin product was used? _____
  - What immunoglobulin dose was used? _____
  - How long was immunoglobulin used for? _____
  - Plate response (include dates of labs): _____
  - What treatment-limiting ADR occurred (provide a description and the date of the reaction): _____

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