PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **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.

Promacta® (eltrombopag)

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

☐ New Request ☐ Continuation Request

Drug product:

☐ Promacta 12.5 mg tablet
☐ Promacta 25 mg tablet
☐ Promacta 50 mg tablet
☐ Promacta 75 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have one of the following conditions and complete applicable step therapy requirements:
   - Chronic immune (idiopathic) thrombocytopenic purpura (ITP)
     i. Have an insufficient response to corticosteroids, immunoglobulin, or splenectomy
     ii. Documentation of a treatment-limiting adverse drug reaction to corticosteroids or immunoglobulin
     iii. Current platelet count less than 50 x 10^9/L with a clinical risk of bleeding
   - Aplastic Anemia (initial approval will be for 16 weeks)
     i. Have an insufficient response to one immunosuppressive agent
     ii. Baseline platelet count must be less than 30 x 10^9/L

For continuation for aplastic anemia after the initial 16 weeks, patient must meet the following requirements:

- Must have a hematologic response defined as either:
  i. Platelet count increase to 20 x 10^9/L above baseline or stable platelet counts with transfusion independence for a minimum of 8 weeks
  ii. Hemoglobin increase by greater than 1.5 g/dL or a reduction in greater than or equal to 4 units of RBC transfusions for 8 consecutive weeks
  iii. ANC increase of 100% or an ANC increase greater than 500/µL

Note: Authorization for indications, dosing, or a route of administration 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 appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 11/2015
Last reviewed 11/2019

PriorityHealth

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Chronic ITP
- ☐ Aplastic anemia
- ☐ Other – rationale for use: _____

B. **What date was the patient diagnosed with chronic ITP or aplastic anemia?** _____

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

Baseline platelet count and date:_____

Most recent platelet count and date: _____

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

- ☐ Splenectomy
- ☐ Corticosteroids
  - Platelet 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? _____
  - Platelet response (include dates of labs): _____
  - What treatment-limiting ADR occurred (provide a description and the date of the reaction): _____

E. Which of the following treatments was used for the patient's aplastic anemia and what was the platelet response?

- ☐ Antithymbocyte globulin, include platelet response and dates of labs: _____
- ☐ Cyclosporine, include platelet response and dates of labs: _____
- ☐ Mycophenolate, include platelet response and dates of labs: _____
- ☐ Cyclophosphamide, include platelet response and dates of labs: _____
- ☐ Other: _____

Continuation
Priority Health Precertification Documentation

For aplastic anemia, patient has shown a hematologic response by:

- ☐ Platelet count increase to 20 x 10^9/L above baseline or stable platelet counts with transfusion independence for a minimum of 8 weeks
- ☐ Hemoglobin increase by greater than 1.5 g/dL or a reduction in greater than or equal to 4 units of RBC transfusions for 8 consecutive weeks
- ☐ ANC increase of 100% or an ANC increase greater than 500/µL
- ☐ Other (rational for continued use): _____

Additional information

Refer to FDA approved label for dosing adjustments. Promacta should be dosed to achieve a platelet count greater than 50 x 10^9/L (not to normal platelet levels). The maximum daily dose of Promacta for treatment of ITP is 75 mg per day, and the maximum daily dose for treatment of aplastic anemia is 150 mg per day.

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Updated 11/2015
Last reviewed 11/2019