PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

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: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically-accepted indication*
   - For chronic idiopathic thrombocytopenic purpura (ITP)
     i. Must try IVIG or immunoglobulin
   - For aplastic anemia
     i. Must try cyclosporine or cyclosporine modified
   - For treatment of thrombocytopenia in a patient with chronic hepatitis C
     i. Must also use interferon-based therapy
2. Must submit the patient's current platelet count test result

Additional information

Note: When criteria are met, coverage duration is 3 months.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018
Last reviewed 11/2019

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Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- —— *or* —— supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

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

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

Date: _____
Platelet count: _____

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

D. Has the patient tried immunoglobulin therapy *(for chronic ITP)*?

- ☐ Yes
- ☐ No – rationale for use: _____

E. Has the patient tried cyclosporine or cyclosporine modified *(for aplastic anemia)*?

- ☐ Yes
- ☐ No – rational for use: _____

F. Is the patient also using interferon-based therapy *(for chronic hepatitis C infection)*?

- ☐ Yes
- ☐ No – rational for use: _____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Promacta likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Promacta, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

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