Promacta (eltrombopag)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Chronic hepatitis C □ Immune (idiopathic) thrombocytopenic purpura (ITP) □ Aplastic Anemia □ Other diagnosis: _____ICD-10:_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

If request is for the Promacta Powder Packets, please also submit documentation why patient cannot swallow tablets or capsules.

Will patient be using Promacta(eltrombopag) in combination with a clinical trial? □ Yes □ No

For chronic hepatitis C, answer the following:
Is the patient's platelet count between 20,000/mcL and 70,000/mcL?* □ Yes □ No
Please submit documentation.

Is Promacta prescribed by a gastroenterology or hematology/oncology specialist? □ Yes □ No

For INITIAL Request of immune (idiopathic) thrombocytopenic purpura (ITP), answer the following:
Is Promacta prescribed by a hematology/oncology specialist? □ Yes □ No

Is the patient's platelet count less than 30,000/mcL OR greater than or equal to 30,000/mcL with additional risk factors for bleeding? □ Yes □ No *Please submit documentation.*

Please submit with chart notes the exact month and year that patient was diagnosed with immune (idiopathic) thrombocytopenic purpura (ITP) _____

For newly diagnosed primary ITP, is the request for Promacta(eltrombopag) within 3 months since the initial date of diagnosis? □ Yes □ No

For persistent primary ITP, is the request for Promacta(eltrombopag) 3 to 12 months since the initial date of diagnosis? □ Yes □ No

For chronic persistent relapsed primary ITP, is the request for Promacta(eltrombopag) greater than or equal to 12 months since the initial diagnosis? □ Yes □ No

Have all other causes of secondary ITP been ruled out such as: Inherited thrombocytopenia, Myelodysplastic Syndrome, HIV, HCV, CLL, drug-induced immune thrombocytopenia, SLE, RA, common variable immune deficiency (CVID), Helicobacter pylori infection, CMV, selective IgA deficiency, autoimmune lymphoproliferative syndrome (ALPS)? □ Yes □ No

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Has the patient had an insufficient response, intolerance or or absolute contraindication to corticosteroids?* □ **Yes** □ **No** ***Please submit documentation.***

Has the patient had an insufficient response, intolerance or or absolute contraindication to immunoglobulins (IVIG)?* □ **Yes** □ **No** ***Please submit documentation.***

Has the patient had an insufficient response, intolerance or absolute contraindication to rituximab?* □ **Yes** □ **No** ***Please submit documentation.***

Has the patient had a splenectomy with an inadequate response? □ **Yes** □ **No**
If "no" to the above question, does the patient have an absolute contraindication to splenectomy?* □ **Yes** □ **No** ***Please submit documentation which includes surgeon or anesthesiologist consultation.***
If "yes" to the above question, has the patient had an insufficient response or intolerance to post-splenectomy corticosteroids?* □ **Yes** □ **No** ***Please submit documentation.***

For patients over 61 years of age, do the results from the most recent bone marrow aspiration show evidence of myelodysplasia as a possible cause for thrombocytopenia?* □ **Yes** □ **No** ***Please submit documentation.***

For <u>RENEWAL</u> Request of <u>immune (idiopathic) thrombocytopenic purpura (ITP):</u>
Is patient continuing to have a positive clinical response? □ **Yes** □ **No** ***Please submit documentation.***

Has the patient had a splenectomy with an inadequate response? □ **Yes** □ **No**
If "no" to the above question, does the patient have an absolute contraindication to splenectomy?* □ **Yes** □ **No** ***Please submit documentation which includes surgeon or anesthesiologist consultation.***

<u>For Aplastic Anemia</u>:
Does patient have an Absolute neutrophil count less than or equal to 500/microliter? □ **Yes** □ **No** ***Please submit documentation.***

Does patient have a Platelet count less than 20,000/microliter? □ **Yes** □ **No** ***Please submit documentation.***

Does patient have an Absolute reticulocyte count less than 60,000/microliter? □ **Yes** □ **No** ***Please submit documentation.***

Does patient have Fanconi's anemia? □ **Yes** □ **No**

Does patient have an SGOT or SGPT more than 5 times the upper limit of normal? □ **Yes** □ **No** ***Please submit documentation.***

Does patient have a clonal disorder consistent with myelodysplasia? □ **Yes** □ **No**

Is patient 2 years of age or older? □ **Yes** □ **No**
If yes, does patient weigh more than 12 kg? □ **Yes** □ **No**
If yes, has the patient received treatment for severe aplastic anemia? □ **Yes** □ **No**

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Is patient 18 years of age or older? □ **Yes** □ **No**
If yes, has patient had insufficient response to immunosuppressive therapy for severe aplastic anemia? □ **Yes** □ **No**
Please submit documentation.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811