HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
PROMACTA®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Promacta® (eltrombopag) tablets, ☐ Promacta® (eltrombopag) packets

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
CHRONIC IMMUNE THROMBOCYTOPENIC PURPURA			
1. Has the member had a liver function test (LFT) and complete blood count (CBC), including platelet count and peripheral blood smear?	☐	☐	**Please provide documentation**
2. Is the member 1 year of age or older?	☐	☐	
3. Is the requesting provider a hematologist or oncologist?	☐	☐	
4. Has the member had a trial and failure of corticosteroids? • Failure is defined as platelet count not increasing to at least 50,000/mcL.	☐	☐	**Please provide documentation**
5. Is the platelet count < 30,000/mcL?	☐	☐	**Please provide documentation**
CHRONIC HEPATITIS C- ASSOCIATED WITH THROMBOCYTOPENIA			
1. Has the member had a liver function test (LFT) and complete blood count (CBC), including platelet count and peripheral blood smear?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	
3. Has the member been confirmed to have chronic hepatitis C-associated thrombocytopenia?	☐	☐	**Please provide documentation**
4. Is the requesting provider a gastroenterologist, infectious disease specialist, or a hematologist?	☐	☐	
5. Is the member's platelet count < 75,000/mcL?	☐	☐	**Please provide documentation**

6. Has the member been prescribed interferon for the treatment of chronic hepatitis C, but is unable to initiate therapy or maintain therapy due to the degree of thrombocytopenia?	☐	☐	**Please provide documentation**
SEVERE APLASTIC ANEMIA			
1. Has the member had a liver function test (LFT) and complete blood count (CBC), including platelet count and peripheral blood smear?	☐	☐	**Please provide documentation**
2. Is the member 2 years of age or older?	☐	☐	
3. Has the member been confirmed to have severe aplastic anemia with a bone marrow cellularity < 25% or 25-50% if < 30% of residual cells are hematopoietic?	☐	☐	**Please provide documentation**
4. Does the member have at least two of the following: • blood absolute neutrophil count (ANC) < 500/mL • blood platelet count < 20,000/mcL • blood reticulocyte count < 20,000/mcL	☐	☐	**Please provide documentation**
5. Is the requesting provider a hematologist?	☐	☐	
6. Has the member had a 3-month trial and failure of standard immunosuppressive therapy (e.g. cyclosporine, antithymocyte globulin, or cyclophosphamide)?	☐	☐	**Please provide documentation**
PROMACTA PACKETS FOR SUSPENSION			
1. Is the member < 8 years of age?	☐	☐	
2. Does documentation show the member is unable to swallow or has severe dysphagia preventing the member from taking solid oral medications?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
CHRONIC IMMUNE THROMBOCYTOPENIC PURPURA			
1. Is the request for reauthorization of therapy for chronic thrombocytopenic purpura?	☐	☐	
2. Has the member responded to therapy, defined as a platelet count of at least 50,000/mcL?	☐	☐	**Please provide documentation**
CHRONIC HEPATITIS C- ASSOCIATED WITH THROMBOCYTOPENIA			
1. For reauthorization, has the member responded to treatment, defined as normalization in platelet count and the patient continues on interferon therapy for the treatment of chronic hepatitis C?	☐	☐	**Please provide documentation**
SEVERE APLASTIC ANEMIA			
1. Is the request for reauthorization of therapy for severe aplastic anemia?	☐	☐	
2. Has the member responded to therapy, defined as at least one of the following: • Platelet increase of at least 20,000/mcL above baseline • Transfusion independent and stable platelet counts for at least 8 weeks • Hemoglobin increase by at least 1.5g/dL • Reduction in red blood cell transfusions of at least 4 units for at least 8 weeks • Absolute neutrophil count increase of 100% or increase of at least 500/mcL	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician's Signature:

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Policy PHARM- 060
Origination Date: 02/13/2018
Reviewed/Revised Date: 05/20/2020
Next Review Date: 05/20/2021
Current Effective Date: 06/01/2020