



**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: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://magellanrx.com/member/external/commercial/common/doc/en-us/phi_disclosure_authorization.pdf)

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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES: <input type="checkbox"/> Chronic hepatitis C <input type="checkbox"/> Immune (idiopathic) thrombocytopenic purpura (ITP) <input type="checkbox"/> Aplastic Anemia <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		ICD-10:
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p><i>If request is for the <u>Promacta Powder Packets</u>, please also submit documentation why patient cannot swallow tablets or capsules.</i></p> <p>Will patient be using Promacta(eltrombopag) in combination with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For <u>chronic hepatitis C</u>, answer the following: Is the patient's platelet count between 20,000/mcL and 70,000/mcL? * <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i></p> <p>Is Promacta prescribed by a gastroenterology or hematology/oncology specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For <u>INITIAL Request of immune (idiopathic) thrombocytopenic purpura (ITP)</u>, answer the following: Does the patient have relapsed/refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient had a diagnosis of immune (idiopathic) thrombocytopenic purpura (ITP) for at least 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient had a splenectomy with an inadequate response? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no" to the above question, does the patient have an absolute contraindication to splenectomy? * <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" to the above question, has the patient had an insufficient response or intolerance to post-splenectomy corticosteroids? * <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient had an insufficient response or intolerance to corticosteroids? * <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient had an insufficient response or intolerance to immunoglobulins (IVIG)? * <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		





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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 RENEWAL Request of immune (idiopathic) thrombocytopenic purpura (ITP), please submit chart documentation of patient's positive clinical response since starting Promacta(eltrombopag).

For Aplastic Anemia:

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 12kg? [] Yes [] No

If yes, has the patient received treatment for severe aplastic anemia? [] Yes [] No

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: _____





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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

