# OPTIMA FAMILY CARE MEDALLION 4.0

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions:** ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

**Drug Requested:** **Promacta®** (eltrombopag)

***DRUG INFORMATION:* Complete information below. If incomplete, authorization process will be delayed.**

**Drug Form/Strength**: _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ ***ICD Code, if applicable:*** _____

*****Medical notes must be submitted to support each line checked on this request. *****

***CLINICAL CRITERIA:* Complete below. *ALL* appropriate lines *MUST* be checked to qualify. Authorization process will be delayed if *not* completed. Medical notes/charts *MUST* be submitted to support this request.**

❑ **Diagnosis:** ***(select ONE of the diagnoses below)***

| | |
|---|---|
| ❑ Chronic Immune Thrombocytopenia | ❑ Hepatitis C |
| ❑ Other: _____ | |

❑ ***Patient new to Promacta*:**

| ***Baseline Platelet Count (<75 or 30 x$10^9$/L)*** | | ***Baseline ALT (aminotransferase)*** | |
|---|---|---|---|
| Date _____ | Level _____ | Date _____ | Level _____ |

❑ For **diagnosis** of **Chronic Immune Thrombocytopenia**, patient ***must*** have failed ***two (2)*** of the following: ***(check boxes)***

| | | |
|---|---|---|
| ❑ Corticosteroid | ❑ IVIG | ❑ Insufficient response to Splenectomy |
| ❑ OTHER_____ | | |

❑ For **diagnosis** of **HCV**, is the platelet count less than 75,000/mcl? ❑ YES ❑ NO

❑ Is patient being treated for thrombocytopenia with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy? ❑ YES ❑ NO

***(continue on next page for signature)***

***Medication being provided by (check applicable box(es) below):***

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy: Sentara Norfolk General CM Pharmacy**

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

**DEA OR NPI #:** _____

**REVISED/UPDATED: 7/1/2018**