OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 or authorization 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 may 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 x10^9/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)

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: ~~7/26/2017; 9/2/2017; 12/23/2017;~~ **8/29/2018**;