

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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 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.)

Diagnosis: (select ONE of the diagnoses below)

<input type="checkbox"/> Chronic Immune Thrombocytopenia	<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> 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)

<input type="checkbox"/> Corticosteroid	<input type="checkbox"/> IVIG	<input type="checkbox"/> Insufficient response to Splenectomy
<input type="checkbox"/> OTHER _____		

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

(continue on next page for signature)

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

Physician's office

OR

Specialty Pharmacy:

For Optima Commercial Members:

PropriumRx

For Optima Family Care Members:

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