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 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 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 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~~; **12/23/2017**;