OPTIMA HEALTH PLAN

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: ALL boxes MUST be checked to qualify. Incomplete information will delay authorization process.

❑ ***Choose 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: _____

❑ ***Choose ONE of the diagnoses below:***

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

❑ Corticosteroid ❑ IVIG ❑ Insufficient response to Splenectomy ❑ OTHER_____

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

Medication being provided by a Specialty Pharmacy (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 #: _____

*** Approved by Pharmacy and Therapeutics Committee**: 4/15/17/2013

REVISED/UPDATED: ~~6/17/2013; 4/14/2014; 8/13/2014; 11/2/2014; 12/23/2014; 5/22/2015; 12/28/2015; 8/11/2015; 9/22/2016; 12/21/2016;~~ **8/4/2017**