

Request for Prior Authorization HEMATOPOIETICS/ CHRONIC ITP

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID # 	Patient name	DOB
Patient address		
Provider NPI 	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI 	Pharmacy fax	NDC

Prior authorization is required for hematopoietics/chronic ITP agents. Request must adhere to all FDA approved labeling. Payment for a non-preferred hematopoietic/chronic ITP agent will be considered following documentation of a recent trial and therapy failure with a preferred hematopoietic/chronic ITP agent, when applicable, unless such a trial would be medically contraindicated. Payment will be considered under the following conditions:

Preferred

- ☐ Nplate
☐ Promacta

Non-Preferred

- ☐ Alvaiz
☐ Doptelet

- ☐ Eltrombopag
☐ Mulpleta

- ☐ Promacta Powder
☐ Tavalisse

Strength

Dosage Instructions

Quantity

Days Supply

☐ **Thrombocytopenia with Chronic Immune Thrombocytopenia (ITP) (Alvaiz, Doptelet, Promacta, Nplate, Tavalisse)**

Documentation of an insufficient response to a corticosteroid, immunoglobulin, or splenectomy.

Trial Drug Name: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Has the patient undergone splenectomy? ☐ No ☐ Yes

☐ **Severe Aplastic Anemia (Alvaiz, Promacta)**

1. Patient has documentation of an insufficient response or intolerance to at least one prior immunosuppressive therapy; and
2. Patient has a platelet count $\leq 30 \times 10^9/L$.
3. If criteria for coverage are met, initial authorization will be given for 16 weeks. Documentation of hematologic response after 16 weeks of therapy will be required for further consideration.

Trial Drug Name: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Platelet count: _____ Lab Date: _____

Renewal Requests:

Has patient had a hematologic response after 16 weeks of Promacta therapy? ☐ Yes (attach labs) ☐ No

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HEMATOPOIETICS/
CHRONIC ITP
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☐ **Thrombocytopenia with chronic liver disease in patients scheduled to undergo a procedure (Doptelet, Mulpleta)**

Documentation of the following: 1. Pre-treatment platelet count; and 2. Scheduled dosing prior to procedure; and 3. Therapy completion prior to scheduled procedure; and 4. Platelet count will be obtained before procedure.

Platelet count: _____ Lab Date: _____

Date of scheduled procedure: _____

Date for start of drug treatment: _____

After the last dose, a platelet count will be obtained prior to undergoing the procedure: ☐ Yes ☐ No

☐ **Other Diagnosis:** _____

Reason for use of Non-Preferred drug requiring prior approval: _____

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.