Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Healthcare Programs Prior Authorization Request Form for Use of Promacta (eltrombopag)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone/Fax:	
Prescriber Name:	Prescriber Specialty:	
Requested Dose/Directions:		

Please complete below information for applicable situation, <u>Initiation</u> or <u>Continuation</u> of therapy and attach supporting documentation:

INITIATION OF THERAPY

1. Prescriber is a hematologist and has diagnosed the condition ☐ Yes ☐ No
2. Baseline platelet count _____ (*must be < 30 x 10^9/L*) Date:_____
3. ☐ Lab results and chart notes from the last 12 months are attached (required).
4. Prescriber attests that baseline clinical hematology and liver function tests have been performed and will be measured ***<u>at least monthly</u>*** throughout course of treatment ☐ Yes ☐ No
5. Diagnosis/age requirements:
   - ☐ **Chronic Immune Thrombocytopenia (ITP)**
     - Member age is ≥1 year ☐ Yes ☐ No
     - Member has trialed at least <u>one</u> of the following (circle):
       - Corticosteroids OR immunoglobulins OR rituximab OR splenectomy
     - Member is at increased risk for bleeding due to clinical condition ☐ Yes ☐ No
   - ☐ **First-line treatment of Severe Aplastic Anemia**
     - Member age is ≥2 years: ☐ Yes ☐ No
     - Standard first-line immunosupressive therapy (i.e., h-ATG and cyclosporine) is being used concurrently: ☐ Yes ☐ No
   - ☐ **Refractory Severe Aplastic Anemia (monotherapy)**
     - Member age is ≥ 18 years ☐ Yes ☐ No
     - Member had an insufficient response to at least one prior immunosuppressive therapy ☐ Yes ☐ No

<u>LIMITATIONS</u>: ITP, max daily 75mg. Severe Aplastic Anemia, max daily 150 mg. **Initial authorization for 6 months.**

CONTINUATION OF THERAPY

1. Diagnosis for treatment:
   - ☐ ITP
     - Provide current platelet count: _____ (*must be > 50 x 10^9/L)* Date: _____ AND/OR documentation that member has experienced a reduction in clinically significant bleeds [*attach platelet lab results and chart notes for last 6 months*]
   - ☐ Refractory Severe Aplastic Anemia Monotherapy
     - Provide platelet, ANC, and hemoglobin levels for the last 6 months and chart notes documenting clinical improvement

2. Clinical hematology and liver function tests will continue to be monitored ***<u>at least monthly</u>***: ☐ Yes ☐ No

Reauthorization will be issued for 6 months.

Please complete form, including required attachments and fax to Medicaid Drug Prior Authorization Unit at 1-800-294-1350.