



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at [www.mercycareaz.org/providers/complecare-forproviders/pharmacy](http://www.mercycareaz.org/providers/complecare-forproviders/pharmacy)

## Thrombopoiesis Stimulating Products Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently

**REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis**

Member Information					
Member Name (first & last):		Date of Birth:		Gender:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
Member ID:		City:		State:	
				Weight:	
Prescribing Provider Information					
Provider Name (first & last):		Specialty:		NPI#	
				DEA#	
Office Address:		City:		State:	
				Zip Code:	
Office Contact:		Office Phone		Office Fax:	
Dispensing Pharmacy Information					
Pharmacy Name:		Pharmacy Phone:		Pharmacy Fax:	
Requested Medication Information					
Preferred Agents:		<input type="checkbox"/> Promacta tablet		<input type="checkbox"/> Nplate	
Non-Preferred Agents:		<input type="checkbox"/> Tavalisse			
Medication request is NOT for an FDA approved, or compendia supported diagnosis (circle one):		Diagnosis:		ICD-10 Code:	
Yes      No					
What medication(s) has member tried and failed for this diagnosis? Please specify:					
Directions for Use:		Strength:		Dosage Form:	
		Quantity:		Day Supply:	
				Duration of Therapy/Use:	
Are there any contraindications to formulary medications?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please specify:					
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> <b>Urgent</b> – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.			
		Signature: _____			
Clinical Information					
<input type="checkbox"/> <b>Promacta Tablet</b>					
The following labs be monitored at baseline AND regularly throughout therapy:		<input type="checkbox"/> Ocular exam		<input type="checkbox"/> CBC with differentials	
				<input type="checkbox"/> Platelet Count	
				<input type="checkbox"/> LFTs	
<input type="checkbox"/> <b>Chronic Immune Thrombocytopenia - Relapsed or Refractory</b>					
Member had insufficient response to any One of the following:		<input type="checkbox"/> corticosteroids		<input type="checkbox"/> immunoglobulins	
Is request to prevent a major bleed in member with PLT count <30,000/mm3?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is request an attempt to achieve PLT counts in normal range (150,000-450,000/mm3)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> <b>Renewal ONLY</b>					
Was there a PLT increase to >50,000/mm3 to <200,000/mm3?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Was there no PLT increase to >50,000/mm3?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> <b>Hepatitis C with Thrombocytopenia</b>					
Does member have chronic hepatitis C with baseline thrombocytopenia (platelet count < 75,000/mm3), preventing start of interferon-based therapy when an interferon is required?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
The following labs are monitored:		<input type="checkbox"/> CBC with differentials		<input type="checkbox"/> Platelet counts monitored weekly until stable	
				<input type="checkbox"/> Hematology and liver tests will be completed regularly throughout	

					therapy
<input type="checkbox"/> <b>Renewal ONLY</b>					
Did PLT increase to >50,000?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did platelet not increase to >50,000?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Severe Aplastic Anemia</b>					
Will Promacta be used in combination with standard immunosuppressive therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is request for treatment of refractory aplastic anemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is bone marrow biopsy showing <25% of normal cellularity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Is bone marrow biopsy showing <50% of normal cellularity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is absolute neutrophil count <500/mm <sup>3</sup> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Is platelet count <20,000/mm <sup>3</sup> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is absolute reticulocyte count <40,000/mm <sup>3</sup> (value may also be given as percent of RBCs)				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is anemia refractory to previous 1 <sup>st</sup> line treatment, including hematopoietic cell transplantation, or immunosuppressive therapy, with combination of cyclosporine A AND antithymocyte globulin?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member have a platelet count less than 30,000/mm <sup>3</sup>				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Renewal ONLY</b>					
Did platelets increase to ≥50,000/mm <sup>3</sup> ?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Nplate</b>					
Is diagnosis of chronic idiopathic thrombocytopenia NOT due to any other cause (for example myelodysplastic syndrome)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does pediatric member of 1 year or older have chronic idiopathic thrombocytopenia for at least 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is platelet count ≤30 x 10 <sup>9</sup> /L?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there trial and failure, intolerance, or contraindication, to BOTH a corticosteroid AND an immunoglobulin?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has there been an insufficient response to, or is member NOT a candidate for a splenectomy?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Renewal ONLY</b>					
Did member have a response to therapy as evidenced by increased platelet count?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was platelet count < 400 x 10 <sup>9</sup> /L?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member remain at risk for bleeding complications?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Tavalisse</b>					
Does member have diagnosis of chronic, refractory immune thrombocytopenia?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insufficient response to previous TX:	<input type="checkbox"/> Corticosteroid	<input type="checkbox"/> Splenectomy	<input type="checkbox"/> IVIG	<input type="checkbox"/> Anti-D globulin	<input type="checkbox"/> Thrombopoietin Receptor Agonists (Promacta, Nplate)
Was there trial and failure, or contraindication to Promacta tablet AND Nplate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is baseline PLT count <30 x 10 <sup>9</sup> /L?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will provider monitor CBCs, AND platelet counts monthly, until stable PLT count (50 x 10 <sup>9</sup> /L) is achieved?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will provider monitor LFTs such as ALT, AST, and bilirubin monthly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will provider monitor BP every 2 weeks until establishment of stable dose, then monthly thereafter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will Tavalisse be used concurrently with IVIG, rituximab, or thrombopoietin receptor agonist (Nplate, Promacta)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Renewal ONLY</b>					
Has documentation shown that after 12 weeks, PLT count increased to a level sufficient enough to avoid clinically important bleeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is provider continuing to monitor CBCs, including neutrophils, BP, LFTs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.</b>					

[Empty box for chart notes]

**Signature affirms that information given on this form is true and accurate and reflects office notes.**

**Prescribing Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please note: Incomplete forms or forms without the chart notes will be returned**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.  
Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.