

SENTARA COMMUNITY PLAN (MEDICAID)

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. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Drug Requested: (Select drug below)

<input type="checkbox"/> Promacta[®] (eltrombopag) tablets	<input type="checkbox"/> Promacta[®] (eltrombopag) Packets
<input type="checkbox"/> Alvaiz (eltrombopag) tablets	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- Member must meet **ALL** the following
 - Prescribed by or in consultation with a hematologist or gastroenterologist
 - Baseline clinical hematology laboratory tests and liver function tests have been performed and submitted
 - Completion of the applicable diagnostic criteria below:

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❑ Diagnosis: Severe Aplastic Anemia (SAA)

NOTE: eltrombopag is not indicated for the treatment of patients with myelodysplastic syndrome (MDS)

- ❑ The following clinical/laboratory results and values have been met at the time of diagnosis (**submit all pertinent chart notes and clinical laboratory documentation**):
 - ❑ Bone marrow (BM) biopsy demonstrates marked hypocellular marrow – cellularity < 25% [OR BM cellularity < 50% if < 30% of BM is hematopoietic cells]
 - ❑ **TWO** or more of the following:
 - ❑ Absolute neutrophil count (ANC) < $0.5 \times 10^9/L$
 - ❑ Platelet count < $20 \times 10^9/L$
 - ❑ Reticulocyte count < 1% corrected or < $20 \times 10^9/L$
- ❑ Member must meet **ONE** of the following:
 - ❑ **For Promacta requests only:** Member is ≥ 2 years of age, and eltrombopag will be used as a first-line treatment option in combination with standard immunosuppressive therapy such as antithymocyte globulin and cyclosporine
 - ❑ **For Promacta & Alvaiz requests:** Member is ≥ 18 years of age, the member has had at least a 3-month trial and failed previous therapy with at least **ONE** immunosuppressive therapy such as antithymocyte globulin, cyclosporine, or cyclophosphamide
- ❑ Documentation of platelet levels within the last 30 days has been submitted confirming < $50 \times 10^9/L$

❑ Diagnosis: Chronic Hepatitis C Infection-Associated Thrombocytopenia

- ❑ Member is ≥ 18 years of age
- ❑ Eltrombopag will be used to achieve the target platelet count necessary to initiate antiviral therapy, and to avoid reductions in concomitant interferon-based therapy

NOTE: eltrombopag therapy to be discontinued when antiviral therapy is stopped

- ❑ Documentation of platelet levels within the last 30 days has been submitted confirming < $75 \times 10^9/L$

❑ Diagnosis: Chronic Immune Thrombocytopenia (ITP)

- ❑ Member has a diagnosis of chronic ITP for at least 6 months (OR meets the corticosteroid requirement below)
- ❑ Documentation of platelet levels within the last 30 days has been submitted confirming < $30 \times 10^9/L$
- ❑ Member must meet **ONE** of the following age requirements:
 - ❑ For Promacta requests: Member is 1 year of age or older
 - ❑ For Alvaiz requests: Member is 6 years of age or older

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- Member has previously failed **ONE** of the following treatments for ITP:
 - Member has failed previous therapy with corticosteroids at a recommended dose of 0.5-2.0 mg/kg prednisone per day (failure defined as not having a response to at least a 3-month trial or is corticosteroid-dependent)
 - Member has failed previous therapy with IVIG
 - Member has had a splenectomy

Reauthorization: All indications 6 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- Documentation of platelet levels within the last 2 to 4 weeks of this request has been submitted confirming **ONE** of the following:
 - Platelet count $< 50 \times 10^9/L$
 - Platelet count $\geq 50 \times 10^9/L$ to $200 \times 10^9/L$
 - Platelet count $\geq 200 \times 10^9/L$ to $\leq 400 \times 10^9/L$, with adjustment to reduce daily dose
- For Hepatitis C Infection-Associated Thrombocytopenia**, the member continues to receive interferon-based therapy
- Clinical hematology laboratory tests and liver function tests have been monitored regularly and the most recent results are submitted
- Member is **NOT** experiencing any signs or symptoms of hepatic injury or thromboembolism
- Ongoing therapy will **NOT** be in combination with another thrombopoietin receptor agonist or with Tavalisse[®] (fostamatinib)

Medication being provided by Specialty Pharmacy – Proprium Rx

*****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.****