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)

❑ **Promacta®** (eltrombopag) **tablets**	❑ **Promacta®** (eltrombopag) **Packets**

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, if applicable:** _____

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.

- ❑ The requesting provider is a hematologist, gastroenterologist, or has been in consultation with one

AND

- ❑ Baseline clinical hematology laboratory tests and liver function tests have been performed and submitted

AND

- ❑ Completion of the applicable diagnostic criteria below:

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❑ **Diagnosis: Severe Aplastic Anemia (SAA).**
Maximum dose: 150 mg/day, 6 months [or THREE 25mg oral suspension packets for ages 2-11 years old]

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 (Please 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]

    AND
  - ❑ **TWO** or more of the following:
    - ❑ Absolute neutrophil count (ANC) < 0.5x109/L
    - ❑ Platelet count < 20x109/L
    - ❑ Reticulocyte count < 1% corrected or < 20x109/L

    AND
- ❑ 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.

  OR
- ❑ Member is ≥ 18 years of age, the member has had at least a 3 month trial and failed previous therapy with ONE immunosuppressive therapy such as antithymocyte globulin, cyclosporine, or cyclophosphamide

  AND
- ❑ Documentation of platelet levels within the last 30 days has been submitted confirming < 50 x 109/L

❑ **Diagnosis: Chronic Hepatitis C Infection-Associated Thrombocytopenia**
Maximum dose: 100 mg/day, 6 months

- ❑ Member is ≥ 18 years of age

  AND
- ❑ 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

  AND
- ❑ Documentation of platelet levels within the last 30 days has been submitted confirming < 75 x 109/L

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❑ Diagnosis: Chronic Immune Thrombocytopenia (ITP)

Maximum dose: 75 mg/day, 6 months

- ❑ The member has a diagnosis of chronic ITP for at least 6 months (OR meets the corticosteroid requirement below)

AND

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

AND

- ❑ Member is 1 year of age or older

AND

- ❑ 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 Approval: 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 2-4weeks of this request has been submitted confirming **ONE** of the following:
  - ❑ Platelet count < 50 x 10^9/L
  - ❑ Platelet count ≥ 50 x 109/L to 200 x 10^9/L
  - ❑ Platelet count ≥ 200 x 10^9/L to ≤ 400 x 10^9/L, with adjustment to reduce daily dose

AND

- ❑ **For Hepatitis C Infection-Associated Thrombocytopenia**, the member continues to receive interferon-based therapy

AND

- ❑ Clinical hematology laboratory tests and liver function tests have been monitored regularly and the most recent results are submitted

AND

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- ❑ The member is not experiencing any signs or symptoms of hepatic injury or thromboemobolism

AND

- ❑ Ongoing therapy will not be in combination with another thrombopoietin receptor agonist or with Tavalisse® (fostamatinib)

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pha rmacy paid claims or submitted chart notes.