# SENTARA HEALTH PLANS

## 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 may 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:** _____

**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:

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

**(Continued on next page)**

## 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

### ❑ 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**

**(Continued on next page)**

- ❑ 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**

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

**AND**

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

**Medication being provided by Specialty Pharmacy - PropriumRx**

***Not all drugs may be covered under every Plan***

***If a drug is non-formulary on a Plan, documentation of medical necessity will be required.***

*****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.****