SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL 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 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

The Sentara Health Plans Oncology Program is administered by OncoHealth

- **For any oncology indications**, the most efficient way to submit a prior authorization request is through the **OncoHealth OneUM Provider Portal** at https://oneum.oncohealth.us. Fax to **1-800-264-6128.** OncoHealth can also be contacted by Phone: 1-888-916-2616.

Drug Requested: Nplate® (romiplostim) **(J2802) (Medical)**

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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

☐ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Dosing Limits:

A. Quantity Limit (max daily dose) [NDC Unit]:

- Nplate 125 mcg SDV for injection: 40 vials per 28 days
- Nplate 250 mcg SDV for injection: 20 vials per 28 days
- Nplate 500 mcg SDV for injection: 12 vials per 28 days

(Continued on next page)

B. Max Units (per dose and over time) [HCPCS Unit]:

- Immune (idiopathic) thrombocytopenia (ITP): 1250 billable units weekly
- Hematopoietic Syndrome of Acute Radiation Syndrome (HSARS): 1250 billable units x 1 dose
- Injection, romiplostim, 1 microgram; 1 billable unit = 1 mcg

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 is not on concurrent treatment with any other thrombopoietin receptor agonist or mimetic or fostamatinib
- ❑ Romiplostim is not being used to attempt to normalize platelet count (i.e., use is limited to decreasing the risk of bleeding from thrombocytopenia by increasing platelet levels and not normalizing them)
- ❑ Laboratory values for platelet count are current (i.e., drawn within the previous 28 days, **NOTE**: Does not apply to patients receiving treatment for Hematopoietic Syndrome of Acute Radiation Syndrome (HS-ARS))
- ❑ Applicable diagnosis criteria below has been completed

❑ Diagnosis: Hematopoietic Syndrome of Acute Radiation Syndrome (HS-ARS)

- ❑ Member has suspected or confirmed exposure to radiation levels > 2 gray (Gy)
- ❑ Dosed for one-time administration at 10 mcg/kg subcutaneously

❑ Diagnosis: Immune (idiopathic) thrombocytopenia (ITP)

- ❑ Member is at increased risk for bleeding as indicated by platelet count < 30×10^9/L (30,000 mm^3)
- ❑ **FOR** acute immune (idiopathic) thrombocytopenia (ITP)
  - ❑ Member is at least 18 years of age
  - ❑ Member has previously failed **ONE** of the following treatments for ITP:
    - ❑ Corticosteroids
    - ❑ Immunoglobulins
    - ❑ Splenectomy
- ❑ **FOR** chronic ITP lasting at least 6 months
  - ❑ Member is 1 year of age or older
  - ❑ Member has previously failed **ONE** of the following treatments for ITP:
    - ❑ Corticosteroids
    - ❑ Immunoglobulins
    - ❑ Splenectomy

(Continued on next page)

Reauthorization: 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.

❑ Diagnosis: Hematopoietic Syndrome of Acute Radiation Syndrome (HS-ARS)

- ❖ **Coverage cannot be renewed**

❑ Diagnosis: Immune (idiopathic) thrombocytopenia (ITP)

- ❑ Member continues to meet the relevant criteria identified in the initial criteria
- ❑ Member has an absence of unacceptable toxicity from the drug (e.g., thrombotic/thromboembolic complications, risk of progression of myelodysplastic syndromes to acute myelogenous leukemia)
- ❑ Member is being continuously monitored for a beneficial response to therapy

Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****

***Approved by Pharmacy and Therapeutics Committee**: 9/16/2021
REVISED/UPDATED/REFORMATTED: ~~12/9/2021; 12/23/2021; 12/20/2024, 1/15/2025; 2/28/2025;~~ **6/10/2026**