



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

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:		Height:	
		<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? If yes, please specify:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> Urgent – 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"/> Promacta Tablet					
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"/> Chronic Immune Thrombocytopenia - Relapsed or Refractory					
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"/> Renewal ONLY					
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"/> Hepatitis C with Thrombocytopenia					
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"/> Renewal ONLY						
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"/> Severe Aplastic Anemia						
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 ³ ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Is platelet count <20,000/mm ³ ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is absolute reticulocyte count <40,000/mm ³ (value may also be given as percent of RBCs)					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is anemia refractory to previous 1 st 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 ³					<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY						
Did platelets increase to ≥50,000/mm ³ ?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Nplate						
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 ⁹ /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"/> Renewal ONLY						
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 ⁹ /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"/> Tavalisse						
Does member have diagnosis of chronic immune thrombocytopenia?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
insufficient response to previous treatments:	<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 or Rituxan)	
Was there trial and failure, or contraindication to Promacta tablet AND Nplate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Is baseline platelet count <30 x 10 ⁹ /L?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will provider monitor CBCs, AND platelet counts monthly, until stable platelet count (50 x 10 ⁹ /L) is achieved?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Will provider continue to monitor CBCs, including neutrophils, regularly?	<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 there be concomitant use with a strong CYP3A4 inducer (for example, phenobarbital, carbamazepine)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY						
After 12 weeks, has PLT count increased to a level 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
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.						

[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.