PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Promacta - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Promacta - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Promacta (eltrombopag)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If no, skip to question 5.]

2. Has the patient's platelet count increased to greater than or equal to 50 x 10^9/L in response to Promacta? Y N _____

	NOTE: Submission of medical records is required.	
	[If yes, skip to question 4.]	
3.	Is the patient expected to achieve a platelet count to greater than or equal to 50 x 10^9/L with an additional 6-week course of therapy?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
4.	Is the requested dose less than or equal to the maximum recommended dose?	Y N
	[No further questions.]	
5.	Does the patient have a diagnosis of chronic immune idiopathic thrombocytopenia (ITP)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 10.]	
6.	Does the patient have a platelet count less than 30 x 10^9 AND an insufficient response to corticosteroids, immunoglobulin, or splenectomy?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 9.]	
7.	Does the patient have a documented diagnosis of chronic ITP with a platelet count between 30 x 10^9 and 50 x 10^9/L AND an insufficient response to corticosteroids or immunoglobulin with significant mucous membrane bleeding?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 9.]	
8.	Does the patient have a documented diagnosis of chronic ITP with a platelet count between 30 x 10^9 and 50 x 10^9/L AND an insufficient response to corticosteroids or immunoglobulin with risk factors for bleeding (such as, but no limited to, hypertension, peptic ulcer disease, anticoagulation, recent surgery, etc.)	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
9.	Is the patient 1 year of age or older?	Y N
	[If yes, skip to question 20.]	
	[If no, no further questions.]	
10.	Does the patient have a documented diagnosis of chronic hepatitis C-associated thrombocytopenia?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 13.]	
11.	Will the patient be initiated and maintained on interferon-based hepatitis C therapy?	Y N

NOTE: Submission of medical records is required.	
[If no, no further questions.]	
12. Is the patient 18 years of age or older?	Y N
[If yes, skip to question 20.]	
[If no, no further questions.]	
13. Does the patient have a diagnosis of aplastic anemia?	Y N
[If no, no further questions.]	
14. Is the requested drug being used as first-line treatment of severe aplastic anemia?	Y N
[If no, skip to question 17.]	
15. Does the patient have a documented diagnosis of severe aplastic anemia AND documentation that the patient will be on a concurrent regimen of standard immunosuppressive therapy?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
16. Is the patient 2 years of age or older?	Y N
[If yes, skip to question 20.]	
[If no, no further questions.]	
17. Is the requested drug being used as refractory treatment of severe aplastic anemia?	Y N
[If no, no further questions.]	
18. Does the patient have a documented diagnosis of severe aplastic anemia with insufficient response to immunosuppressive therapy?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
19. Is the patient 18 years of age or older?	Y N
[If no, no further questions.]	
20. Is the requested dose less than or equal to the maximum recommended dose?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date