



Prior Authorization
JOHNS HOPKINS HEALTHCARE (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 Healthcare at 1-410-424-4607 . Please contact Johns Hopkins Healthcare 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: _____
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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)?	<input type="checkbox"/> Y <input type="checkbox"/> 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 $50 \times 10^9/L$ in response to Promacta?	<input type="checkbox"/> Y <input type="checkbox"/> 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 $50 \times 10^9/L$ with an additional 6-week course of therapy?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
5. Does the patient have a diagnosis of chronic immune idiopathic thrombocytopenia (ITP)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 10.]	
6. Does the patient have a platelet count less than 30×10^9 AND an insufficient response to corticosteroids, immunoglobulin, or splenectomy?	<input type="checkbox"/> Y <input type="checkbox"/> 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 30×10^9 and $50 \times 10^9/L$ AND an insufficient response to corticosteroids or immunoglobulin with significant mucous membrane bleeding?	<input type="checkbox"/> Y <input type="checkbox"/> 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 30×10^9 and $50 \times 10^9/L$ 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.)	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Is the patient 1 year of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N

NOTE: Submission of medical records is required.	
[If no, no further questions.]	
12. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 20.]	
[If no, no further questions.]	
13. Does the patient have a diagnosis of aplastic anemia?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
14. Is the requested drug being used as first-line treatment of severe aplastic anemia?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
16. Is the patient 2 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
18. Does the patient have a documented diagnosis of severe aplastic anemia with insufficient response to immunosuppressive therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
19. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
20. Is the requested dose less than or equal to the maximum recommended dose?	<input type="checkbox"/> Y <input type="checkbox"/> 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
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