Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Thrombopoietics

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for continuation of therapy with the requested product?
[If NO, skip to 13.]

☐ Yes ☐ No

Q2. Is the requested product prescribed for thrombocytopenia in a patient scheduled to undergo a procedure that was previously approved?

☐ Yes ☐ No

Q3. Is this request for Doptelet (avatrombopag) or Mulpleta (lusutrombopag
[If YES, skip to 14.]

☐ Yes ☐ No

Q4. Is the requested product prescribed by or in consultation with an appropriate specialist (i.e., hematologist/oncologist, gastroenterologist, hepatologist, etc.)?

☐ Yes ☐ No

Q5. Is the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q6. Has the patient had a documented increase in platelet count sufficient to avoid bleeding that requires medical attention?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q7. Is this request for the treatment of severe aplastic anemia?

☐ Yes ☐ No

Q8. Is there documentation of a positive clinical response to the requested product?

☐ Yes ☐ No

Q9. Is there documentation of repeat lab results and monitoring as recommended in the Food and Drug Administration (FDA)-approved package labeling?

☐ Yes ☐ No

Q10. Is this request for Tavalisse (fostamatinib)?

☐ Yes ☐ No

Q11. Does the patient have diarrhea that is greater than or equal to grade 3?

☐ Yes ☐ No

Q12. Is there a documented plan to manage the diarrhea that is consistent with Food and Drug Administration (FDA)-approved package labeling?

☐ Yes ☐ No

Q13. Is this request for Doptelet (avatrombopag), Mulpleta (lusutrombopag), or Tavalisse (fostamatinib)?

☐ Yes ☐ No

Q14. Does the patient have documented therapeutic failure, contraindication, or intolerance to the preferred thrombopoietics approved for the patient's indication?

☐ Yes ☐ No

Q15. Is this request for Nplate (romiplostim) or Promacta (eltrombopag)?

☐ Yes ☐ No

Q16. Is the requested product prescribed by or in consultation with an appropriate specialist (i.e., hematologist/oncologist, gastroenterologist, hepatologist, etc.)?

☐ Yes ☐ No

Q17. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q18. Is the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q19. Is there documentation of baseline lab results and monitoring as recommended in the Food and Drug Administration (FDA)-approved package labeling?	
☐ Yes	☐ No
Q20. Is the requested drug prescribed for the treatment of thrombocytopenia prior to a procedure?	
☐ Yes	☐ No
Q21. Does the patient have a documented pretreatment platelet count of less than 50,000 cells per microliter?	
☐ Yes	☐ No
Q22. Will the patient begin treatment with the requested product prior to the scheduled procedure in accordance with Food and Drug Administration (FDA)-approved package labeling?	
☐ Yes	☐ No
Q23. Does the patient have a documented pretreatment platelet count of less than 30,000 cells per microliter?	
☐ Yes	☐ No
Q24. Is the requested product prescribed for the treatment of immune thrombocytopenia (ITP)?	
☐ Yes	☐ No
Q25. Is this request for Promacta (eltrombopag) prescribed for the treatment of refractory severe aplastic anemia?	
☐ Yes	☐ No
Q26. Is this request for Promacta (eltrombopag) prescribed for the primary treatment of aplastic anemia?	
☐ Yes	☐ No
Q27. Additional Information:	

_____ _____

Prescriber Signature Date

Updated for 2023