## 2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Promacta - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Jefferson Health 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:	Prescriber Name:	
Member Number:		Fax: Phone:	ix: Phone:	
Date of Birth:		Office Contact:	Office Contact:	
Line of Business:   Medicare		NPI: State Lic ID:	NPI: State Lic ID:	
Address:		Address:		
City, State ZIP:		City, State ZIP:	City, State ZIP:	
Primary Phone:		Specialty/facility name (if applicable):	Specialty/facility name (if applicable):	
	<u>DITED REVIEW</u> : By checking this box and sign enrollee or the enrollee's ability to regain m	gning below, I certify that applying the 72 hour standard review timeframe may seriously aximum function.	jeopardize	
Drug Name:				
Strength:				
Directions / SIG:				
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. Does the patient have the diagnosis of thrombocytopenia in a patient with chronic immune thrombocytopenia (ITP)?				
☐ Yes		□No		
Q2. Is the patient 1 year of age or older?				
☐ Yes		□No		
Q3. Has the patient had an inadequate response, intolerance or contraindication to glucocorticoids (prednisone, dexamethasone, or methylprednisolone), immunoglobulins, or splenectomy?				
☐ Yes		□No		
Q4. Does the patient have the diagnosis of thrombocytopenia in a patient with chronic hepatitis C?				
□Yes		□No		
Q5. Is the pa	tient 18 years of age or old	er?		
☐ Yes		□ No		
	•	ocytopenia prevented the initiation of interferon-based interferon-based therapy?		

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Patient Name:	Prescriber Name:			
□Yes	□ No			
Q7. Does the patient have the diagnosis of severe aplastic anemia?				
☐Yes	□No			
Q8. Is the patient 2 years of age or older?				
☐ Yes	□No			
Q9. Has the patient had an inadequate response, intolerance or contraindication to immunosuppressive therapy, or will Promacta be used in combination with standard immunosuppressive therapy?				
☐ Yes	□ No			
Q10. Is Promacta being prescribed by or in consultation with a hematologist?				
☐ Yes	□ No			
Q11. Is Promacta being prescribed by or in consultation with a hematologist, hepatologist, or infectious disease specialist?				
☐Yes	□No			
Q12. Requested Duration:				
☐ 12 months	☐ Other			
Q13. Additional Information:				
Prescriber Signature	Date			
	2024 Medicare Prior Authorization Request			