

Promacta (Eltrombopag) Prior Authorization Form



Physicians Plus
INSURANCE CORPORATION

START HERE

**Member &
Prescriber
Information**

Member Name:	Prescriber Name:
	Prescriber Specialty:
Member Date of Birth:	Prescriber Phone #:
Member ID #:	Prescriber Fax #:

Criteria

Must have chronic immune thrombocytopenic purpura, be >18yrs old and baseline platelet count <50,000/ml

Secondary causes of thrombocytopenia, not eligible for coverage.

Patient under the care of a hematologist.

Patient must have failed 2 or more therapeutic approaches listed.

Initial approval length is 12 months; reauthorization required; minimum effective dose is 50mg once daily; max approved dose is 75mg once daily. Target platelets >50,000

Promacta not covered for secondary causes of thrombocytopenia including but not limited to HIV, myelodysplastic syndrome, drug-induced or other cancers — use is considered experiemntal. Patients with the following comorbid conditions were explicitly excluded from clinical trials: congestive heart failure; myocardial infarction in previous 3 months; hepatitis B or C; thromboembolism in previous 12 months; abnormal liver enzymes; impaired renal function; neutropenia; and systemic lupus erythmatosus.

Diagnosis:

Patient new to Promacta (Eltrombopag)

Baseline Platelet Count		Baseline ALT (aminotransferase)	
Date	Level (ref. range)	Date	Level (ref. range)

Therapies used for the treatment of this patient's ITP (select at least 2)

- | | |
|---|--|
| <input type="checkbox"/> Corticosteroids | <input type="checkbox"/> Azathioprine |
| <input type="checkbox"/> Cyclosporine | <input type="checkbox"/> Mycophenolate |
| <input type="checkbox"/> Platelet transfusion | <input type="checkbox"/> Intravenous Immune globulin (Win Rho) |
| <input type="checkbox"/> Other: _____ | |

Patient continuing Promacta (Eltrombopag) therapy

Current Promacta Regimen:
Platelet Count (date):

**Choose
Regimen**

- Promacta** 25mg once daily
- Promacta** 50mg once daily
- Promacta** 75mg once daily

**Sign/Date &
Mail or Fax**

Prescriber Signature: _____ Date: _____

Prescriber NPI: _____

Mailing Address

Physicians Plus Insurance Corporation
Attn: Pharmacy Services
P.O. Box 2078
Madison WI 53701-2078

Physicians Plus Pharmacy Services Fax:

(608) 258-1905

Prior Authorization Questions?

(608) 260-7803 or (800) 545-5015 (ext. 7803)

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