THROMBOPOIETICS PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Thrombopoietics** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html

☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Weight:
Dose/directions:	Quantity:	Duration:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Complete all sections that apply to the member and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

☐ **For ALL requests:**
- ☐ Has recent results of a CBC with differential
- ☐ Has recent results of liver function tests *(if recommended in the FDA-approved package labeling [e.g., Alvaiz, Promacta, Tavalisse])*

☐ **For treatment of thrombocytopenia prior to a procedure:**

Planned procedure date: _____ Planned administration date: _____

- ☐ Has chronic liver disease
- ☐ Has a pretreatment platelet count <50 x 10^9/L

☐ **For treatment of immune thrombocytopenia:**

Duration of thrombocytopenia: _____

- ☐ Has a pretreatment platelet count <30 x 10^9/L
- ☐ Had an insufficient response to previous treatment. Other treatments tried:
  - ☐ corticosteroids
  - ☐ immune globulin
  - ☐ rituximab
  - ☐ splenectomy
  - ☐ other: _____

☐ **For treatment of severe aplastic anemia:**
- ☐ Had an insufficient response to immunosuppressive therapy
- ☐ Will be used in combination with standard immunosuppressive therapy as first-line treatment
- ☐ Has one of the following:
  - ☐ marrow cellularity <25%
  - ☐ marrow cellularity 25-50% with <30% residual hematopoietic cells
- ☐ Has two of the following:
  - ☐ neutrophil count <0.5 x 10^9/L
  - ☐ platelet count <20 x 10^9/L
  - ☐ reticulocyte count <60 x 10^9/L (using an automated reticulocyte count)

☐ **For treatment of thrombocytopenia with chronic hepatitis C virus infection:**
- ☐ Is or will be receiving interferon therapy
- ☐ Has a pretreatment platelet count <30 x 10^9/L

☐ **For all other indications:**
- ☐ Has a pretreatment platelet count <30 x 10^9/L

☐ **For a NON-PREFERRED Thrombopoietic:**
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Thrombopoietics that are approved or medically accepted for treatment of the member's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.):*_____

RENEWAL requests

pa health & wellness™

☐ **For ALL requests:**
- ☐ Has recent results of a CBC with differential
- ☐ Has recent results of liver function tests *(if recommended in the FDA-approved package labeling [e.g., Alvaiz, Promacta, Tavalisse])*

☐ **For treatment of severe aplastic anemia:**
- ☐ Experienced a positive clinical response since starting the requested drug

☐ **For all treatment of all other conditions:**
- ☐ Platelet count increased to a level sufficient to avoid bleeding that requires medical attention

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)