OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Promacta® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Chronic hepatitis C-associated thrombocytopenia
- ❑ Chronic idiopathic thrombocytopenic purpura (ITP)
- ❑ Severe aplastic anemia
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if Promacta is prescribed by or in consultation with one of the following specialists:

- ❑ Gastroenterologist
- ❑ Hematologist/oncologist
- ❑ Hepatologist
- ❑ HIV specialist certified through the American Academy of HIV Medicine
- ❑ Infectious disease specialist

For chronic idiopathic thrombocytopenic purpura (ITP), answer the following:

Select the patient's diagnosis:

- ❑ Chronic immune (idiopathic) thrombocytopenic purpura (ITP)
- ❑ Relapsed/refractory ITP

Is the patient's baseline platelet count less than 30,000/microliter? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

❑ Corticosteroids ❑ Immunoglobulins ❑ Splenectomy

Does the patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to Promacta therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinical important bleeding? ❑ **Yes** ❑ **No**

For chronic hepatitis C-associated thrombocytopenia, answer the following:

Does the patient have a diagnosis of chronic hepatitis C-associated thrombocytopenia? ❑ **Yes** ❑ **No**

Is the patient planning to initiate and maintain interferon-based treatment? ❑ **Yes** ❑ **No**

Is the patient currently receiving interferon-based therapy? ❑ **Yes** ❑ **No**

Reauthorization:

Is the patient currently receiving interferon-based therapy? ❑ **Yes** ❑ **No**

For patients that started treatment with Promacta prior to initiation of treatment with interferon, is there documentation the patient has reached a threshold platelet count that allows initiation of antiviral interferon therapy with Promacta treatment by week 9? ❑ **Yes** ❑ **No**

Promacta® Prior Authorization Request Form (Page 2 of 2)

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For severe aplastic anemia, answer the following:

Has the patient had trial and failure, contraindication, or intolerance to immunosuppressive therapy with antithymocyte globulin (ATG) and cyclosporine? ❑ **Yes** ❑ **No**

Does the patient have thrombocytopenia, defined as a platelet count less than 30,000/microliter? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to Promacta therapy as evidenced by an increase in platelet count? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.