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

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

Is Promacta prescribed by or in consultation with a hematologist/oncologist? ❑ **Yes** ❑ **No**

Has the patient had relapsed or refractory chronic ITP for more than 6 months? ❑ **Yes** ❑ **No**

Does the patient have a baseline platelet count less than 50,000/mcL? ❑ **Yes** ❑ **No**

Is the patient's degree of thrombocytopenia and clinical condition indicative of increased risk for bleeding? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to corticosteroids, immunoglobulins, or splenectomy? ❑ **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 clinically important bleeding? ❑ **Yes** ❑ **No**

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

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

Is Promacta prescribed by or in consultation with a hematologist/oncologist, gastroenterologist, hepatologist, infectious disease specialist, or HIV specialist certified through the Academy of HIV Medicine? ❑ **Yes** ❑ **No**

Reauthorization:

Is the patient currently on antiviral interferon therapy for treatment of chronic hepatitis C? ❑ **Yes** ❑ **No**

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

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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

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For severe aplastic anemia, answer the following:

Is Promacta prescribed by or in consultation with a hematologist/oncologist? ❑ **Yes** ❑ **No**

Does the patient have a platelet count less than 30,000/mcL? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to immunosuppressive therapy [e.g., Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit)]? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to cyclosporine? ❑ **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**

Quantity Limit:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading-dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____

❑ Other: _____

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.

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