08/26/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Promacta (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Promacta (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Promacta (eltrombopag)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 8.]

2. Does the patient have a diagnosis of chronic idiopathic thrombocytopenic purpura (ITP)? Y N

   [If no, skip to question 4.]

3. Does the patient have a platelet count of at least 50,000/mm3? Y N

   [No further questions.]

4. Does the patient have a diagnosis of interferon-induced thrombocytopenia? Y N

   [If no, skip to question 6.]

5. Does the patient have a platelet count of at least 50,000/mm3? Y N

   [No further questions]

6. Does the patient have a diagnosis of aplastic anemia? Y N

   [If no, no further questions.]

7. Has the patient had a response to treatment indicated by an improvement in platelets, RBC or WBC? Y N

   [No further questions.]

8. Is the patient 18 years of age or older? Y N

   [If no, no further questions.]

9. Does the patient have a diagnosis of idiopathic thrombocytopenic purpura (ITP)?

   [If no, skip to question 12.]

10. Prior to initiation of therapy with Promacta, did the patient have an insufficient response to corticosteroids, immunoglobulins, or splenectomy? Y N

    [If no, no further questions.]

11. Is Promacta being used to prevent major bleeding (not in an attempt to achieve platelet counts in the normal range i.e., 150,000-450,000/mm3)? Y N

    [No further questions.]

12. Is Promacta requested to treat thrombocytopenia due to chronic hepatitis C infection which is preventing initiation or ability to maintain interferon-based therapy? Y N

    [If yes, no further questions.]

13. Does the patient have a diagnosis of severe aplastic anemia Y N

defined by at least 2 of the following?

Neutrophil count less than 0.5x1,000,000,000/L \ Platelet count less than 20x1,000,000,000/L \ Reticulocyte count less than 20x1,000,000,000/L (value may be given as percent of RBCs)

[If no, no further questions.]

14. Has the patient had a trial of or contraindication to first line treatment including allogeneic stem cell transplantation from an appropriate sibling donor or immunosuppressive therapy with a combination of cyclosporine A and antithymocyte globulin (ATG)? Please document previous treatment or describe contraindication(s) if applicable: _____ Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date