Prescriber Criteria Form Promacta 2024 PA Fax 592-A v2 010124.docx Promacta (eltrombopag) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Promacta (eltrombopag).

Drug Name: Promacta (eltrombopag)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of chronic or persistent immune thrombocytopenia (ITP)? [If no, then skip to question 8.]	Yes	No
2	Is the patient currently receiving therapy with the requested drug? [If yes, then skip to question 7.]	Yes	No
3	Has the patient had an inadequate response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins? [If no, then no further questions.]	Yes	No
4	At any point prior to the initiation of the requested medication, did the patient meet either of the following criteria: A) untransfused platelet count less than 30,000 cells per microliter, B) untransfused platelet count 30,000 to 50,000 cells per microliter with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma)? [If no, then no further questions.]	Yes	No
5	Does the patient have a diagnosis of chronic immune thrombocytopenia (ITP)? [If no, then no further questions.]	Yes	No

6	Has the patient had an inadequate response or intolerance to Doptelet (avatrombopag)? [No further questions.]	Yes	No
7	Did the patient's platelet count respond to the requested drug as evidenced by either of the following: A) current platelet count is less than or equal to 200,000 cells per microliter, B) current platelet count is greater than 200,000 cells per microliter to less than or equal to 400,000 cells per microliter and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding? [No further questions.]	Yes	No
8	Does the patient have a diagnosis of thrombocytopenia associated with chronic hepatitis C? [If no, then skip to question 12.]	Yes	No
9	Is the patient currently receiving treatment with the requested drug? [If no, then skip to question 11.]	Yes	No
10	Is the patient currently receiving interferon-based therapy? [No further questions.]	Yes	No
11	Will the requested drug be used for the initiation and maintenance of interferon-based therapy? [No further questions.]	Yes	No
12	Does the patient have a diagnosis of severe aplastic anemia? [If no, then no further questions.]	Yes	No
13	Is the patient currently receiving treatment with the requested drug? [If yes, then skip to question 16.]	Yes	No
14	Will the requested drug be used in combination with standard immunosuppressive therapy for first-line treatment? [If yes, then no further questions.]	Yes	No
15	Has the patient tried and had an insufficient response to immunosuppressive therapy? [No further questions.]	Yes	No
16	Did the patient's platelet count respond to the requested drug as evidenced by either of the following: A) current platelet count is 50,000 to 200,000 cells per microliter, B) current platelet count is greater than 200,000 cells per microliter to less than or equal to 400,000 cells per microliter and dosing will be adjusted to achieve and maintain an appropriate target platelet count? [If yes, then no further questions.]	Yes	No
17	Is the patient's current platelet count less than 50,000 cells per microliter? [If no, then no further questions.]	Yes	No
18	Is the patient transfusion-independent? [If yes, then no further questions.]	Yes	No

19	Has the patient received appropriately titrated therapy with the requested drug for at least 16 weeks?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____