



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Nplate

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

<p>Patient Name:</p> <p>Member Number:</p> <p>Date of Birth:</p> <p>Group Number:</p> <p>Address:</p> <p>City, State, Zip:</p> <p>Member Phone:</p>	<p>Prescriber Name:</p> <p>Fax: Phone:</p> <p>Office Contact:</p> <p>NPI: State Lic ID:</p> <p>Address:</p> <p>City, State, Zip:</p>
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Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

<p>Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:</p>
<p>Q1. What is the duration of the therapy requested?</p> <p style="padding-left: 40px;">1 month or less More than 1 month</p>
<p>Q2. Has the patient received Nplate therapy in the previous month?</p> <p style="padding-left: 40px;">Yes No</p>
<p>Q3. Does the patient have the diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP)?</p> <p style="padding-left: 40px;">Yes No</p>
<p>Q4. Have you submitted post-treatment complete blood counts (CBCs), including platelet counts and peripheral blood smears? Labs must be attached.</p> <p style="padding-left: 40px;">Yes No</p>
<p>Q5. Has the dose been adjusted to maintain a platelet count $\geq 50 \times 10^9/L$?</p> <p style="padding-left: 40px;">Yes No</p>
<p>Q6. What is the patient's weight (kg)?</p>
<p>Q7. Comments:</p>
<p>Q8. Deliver to:</p> <p style="padding-left: 40px;">Physician's Office Home</p>
<p>Q9. Delivery date needed:</p>

Physician Signature

Date