# PRIOR AUTHORIZATION REQUEST FORM

**EOC ID:**

**Promacta**

**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.**

| **Patient Name:** | **Prescriber Name:** | |
|---|---|---|
| Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Group Number: | NPI: | State Lic ID: |
| Address: | Address: | |
| City, State, Zip: | City, State, Zip: | |
| Member Phone: | | |

Drug Name: Expedited/Urgent

Directions:

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

| **Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:** |
|---|
| Q1. What is the duration of the therapy requested?<br>1 month or less More than 1 month |
| Q2. Has the patient received Promacta therapy in the previous month?<br>Yes No |
| Q3. Does the patient have the diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP)?<br>Yes No |
| Q4. Have you submitted post-treatment complete blood counts (CBCs), including platelet counts and peripheral blood smears? Labs must be attached.<br>Yes No |
| Q5. Has the dose been adjusted to maintain a platelet count ≥ 50 x 109/L?<br>Yes No |
| Q6. Comments: |
| Q7. Deliver to:<br>Physician's Office Home |
| Q8. Delivery date needed: |

**Physician Signature** **Date**

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