iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
HEMATOPOIETICS/ CHRONIC ITP
(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for hematopoietics/chronic ITP agents. Request must adhere to all FDA approved labeling. Payment for a non-preferred hematopoietic/chronic ITP agent will be considered following documentation of a recent trial and therapy failure with a preferred hematopoietic/chronic ITP agent, when applicable, unless such a trial would be medically contraindicated. Payment will be considered under the following conditions:

Preferred
- ☐ Nplate
- ☐ Promacta

Non-Preferred
- ☐ Alvaiz
- ☐ Doptelet
- ☐ Eltrombopag
- ☐ Mulpleta
- ☐ Promacta Powder
- ☐ Tavalisse

Strength	Dosage Instructions	Quantity	Days Supply

☐ **Thrombocytopenia with Chronic Immune Thrombocytopenia (ITP) (Alvaiz, Doptelet, Promacta, Nplate, Tavalisse)**

Documentation of an insufficient response to a corticosteroid, immunoglobulin, or splenectomy.

Trial Drug Name:_____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Has the patient undergone splenectomy? ☐ No ☐ Yes

☐ **Severe Aplastic Anemia (Alvaiz, Promacta)**

1. Patient has documentation of an insufficient response or intolerance to at least one prior immunosuppressive therapy; and
2. Patient has a platelet count ≤ 30 x 10^9/L. 3. If criteria for coverage are met, initial authorization will be given for 16 weeks. Documentation of hematologic response after 16 weeks of therapy will be required for further consideration.

Trial Drug Name:_____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Platelet count:_____Lab Date: _____

Renewal Requests:
Has patient had a hematologic response after 16 weeks of Promacta therapy? ☐ Yes (attach labs) ☐ No

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
HEMATOPOIETICS/ CHRONIC ITP

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Thrombocytopenia with chronic liver disease in patients scheduled to undergo a procedure (Doptelet, Mulpleta)**

Documentation of the following: 1. Pre-treatment platelet count; and 2. Scheduled dosing prior to procedure; and 3. Therapy completion prior to scheduled procedure; and 4. Platelet count will be obtained before procedure.

Platelet count:_____Lab Date: _____

Date of scheduled procedure: _____

Date for start of drug treatment:_____

After the last dose, a platelet count will be obtained prior to undergoing the procedure: ☐ Yes ☐ No

☐ **Other Diagnosis:**_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Other medical conditions to consider:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*