



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Promacta

Phone: 800-728-7947

Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department 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.

Form with fields for Patient Name, Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Prescriber Name, Supervising Physician, Fax, Office Contact, NPI, Address, City, State ZIP, Specialty/facility name, Phone, and State Lic ID.

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. For what diagnosis is this drug being prescribed (pick one)?
Q2. Please provide the ICD code(s) for the diagnosis above.
Q3. Is this a new start or continuation of therapy?
Q4. If a new start for ITP, has the patient tried and failed corticosteroids, immunoglobulins or splenectomy?
Q5. If a new start for ITP, is the platelet count less than 30,000/mcL?
Q6. If continuation for ITP, has the patient shown a response to treatment with the patient's platelet count being between 50,000/mcL and 200,000/mcL?



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	<b>Supervising Physician:</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. If a new start for HCV associating with thrombocytopenia, is the platelet count less than 75,000/mcL?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. For continuation for HCV, has the patient shown a response to treatment with an improved platelet count from baseline?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. If for severe aplastic anemia, has the patient had an insufficient response to immunosuppressive therapy?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Additional Comments	

Prescriber Signature

Date

Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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