pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

THROMBOPOIETICS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Thrombopoietics** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Weight:
Dose/directions:	Quantity:	Duration:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

INITIAL requests

For a non-preferred Thrombopoietic: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class listed above that are approved or medically accepted for treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.*	☐Yes ☐No *Submit documentation.*

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Has recent results of a CBC with differential
☐Has recent results of liver function tests
☐**For treatment of thrombocytopenia prior to a procedure:** Planned procedure date: _____ Planned administration date: _____
  ☐Has chronic liver disease
  ☐Has a pretreatment platelet count < 50 x 10^9/L
☐**For treatment of immune thrombocytopenia:** Duration of thrombocytopenia: _____
  ☐Has a pretreatment platelet count < 30 x 10^9/L
  ☐Had an insufficient response to corticosteroids, immunoglobulin, and/or splenectomy
☐**For treatment of severe aplastic anemia:**
  ☐Had an insufficient response to immunosuppressive therapy
  ☐Has a pretreatment platelet count < 30 x 10^9/L
  ☐Will be used in combination with standard immunosuppressive therapy as first-line treatment
☐**For treatment of thrombocytopenia with chronic hepatitis C virus infection:**
  ☐Is or will be receiving interferon therapy

RENEWAL requests

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Has recent results of a CBC with differential
☐Has recent results of liver function tests
☐**For treatment of severe aplastic anemia:**
  ☐Experienced a positive clinical response since starting the requested medication
☐**For all treatment of all other conditions:**
  ☐Platelet count increased to a level sufficient to avoid bleeding that requires medical attention

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: