HIGHMARK HEALTH OPTIONS

Updated: 05/2022
DMMA Approved: 07/2022

Request for Prior Authorization for Thrombopoietics
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Thrombopoietics require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Thrombopoietics Prior Authorization Criteria:

Thrombopoietics include Doptelet, Mulpleta, Nplate, Promacta, and Tavalisse. New products with this classification will require the same documentation.

For all requests for Thrombopoietics all of the following criteria must be met:

- For non-preferred agents, the member has had a trial and failure of a preferred agent or a clinically submitted reason for not having a trial of a preferred agent
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines

Coverage may be provided with a diagnosis of chronic immune thrombocytopenia (ITP) and the following criteria is met:

- Must provide documentation of platelet count $\leq 30{,}000/\mu L$ ($30 \times 10^9/L$)
- Must be prescribed by or in consultation with a hematologist or oncologist
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to one of the following:
  - Four-day trial of corticosteroid therapy
  - IVIG therapy*
  - Splenectomy
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
  - Documentation that member is responding positively to therapy by providing ONE of the following since starting therapy:
    - Increase in platelet count
    - Reduction in bleeding events
- **Reauthorization Duration of approval:** 12 months

Coverage may be provided with a diagnosis of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure and the following criteria is met:

- Must provide documentation of platelet count $< 50{,}000/\mu L$ ($50 \times 10^9/L$)
- Must not have a diagnosis of hematologic disorders or have received a platelet transfusion or receipt of blood products containing platelets within 7 days
- Must be used for short-term use prior to a scheduled procedure
- **Duration of Approval:** 1 month

Coverage may be provided with a diagnosis of severe aplastic anemia when the following criteria is met:

- Must provide documentation of platelet count < 30,000/µL (30 x 10^9/L)
- Must be prescribed by or in consultation with a hematologist or oncologist
- Must provide documentation showing one of the following:
    - The member has tried and failed or had an intolerance or contraindication to immunosuppressive therapy (i.e. cyclosporine, Atgam, Thymoglobulin)
    - The member will be using this medication in combination with immunosuppressive therapy (ie. cyclosporine, Atgam, Thymoglobulin)
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
    - Must provide documentation that the member is responding positively to therapy by providing ONE of the following since starting therapy:
        - Increase in platelet count
        - Increase in hemoglobin (Hgb)
        - Increase in absolute neutrophil count (ANC)
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of Hematopoietic Syndrome of Acute Radiation Syndrome (HS-ARS):

- **Duration of Approval:** 1 month

Promacta (eltrombopag) is not covered for the treatment of thrombocytopenia in adults with Hepatitis C to allow the initiation and maintenance of interferon-based therapy. Interferon-based regimens are not recommended in the AASLD-IDSA Guidelines for Hepatitis C Treatment.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

*IVIG requires prior authorization

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THROMBOPOIETICS PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Chronic Immune Thrombocytopenia (ITP):
- Does the member have a platelet count ≤ 30,000/µL? ☐ Yes: platelet count: _____ ☐ No
- Which of the following have been tried? ☐ 4-day course of corticosteroid ☐ Immunoglobulins ☐ Splenectomy

Thrombocytopenia with Chronic Liver Disease (CLD):
- Is the member scheduled to undergo a procedure? ☐ Yes, date of procedure: _____ ☐ No
- Does the member have a platelet count < 50,000/µL? ☐ Yes: platelet count: _____ ☐ No

Severe aplastic anemia:
- Does the member have a platelet count ≤ 30,000/µL? ☐ Yes: platelet count: _____ ☐ No
- Has the member tried immunosuppressive therapy (i.e. cyclosporine, Atgam, Thymoglobulin)? ☐ Yes ☐ No
- Will the requested medication be used in combination with immunosuppressive therapy? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member responded positively to therapy? ☐ Yes ☐ No

If yes, please indicate what improvements have been experienced since starting therapy (check all that apply):

☐ Increase in platelet count ☐ Increase in hemoglobin (Hgb)
☐ Reduction in bleeding events ☐ Increase in absolute neutrophil count (ANC)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date