AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Thrombopoietin Receptor Agonists

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
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:

Payment for a non-preferred thrombopoietin receptor agonist will be considered following documentation of a recent trial and therapy failure with a preferred thrombopoietin receptor agonist unless such a trial would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred:	**Non-Preferred:**
☐ Promacta	☐ Nplate

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

☐ **Chronic Immune Thrombocytopenic Purpura (ITP) (Promacta and Nplate)**

Treatment failure with a preferred corticosteroid or immunoglobulin product:

Documentation of an insufficient response to a corticosteroid, an immunoglobulin, or the patient has undergone splenectomy is required prior to consideration of a thrombopoietin receptor agonist.

Trial Drug Name: Trial start date: Trial end date:

Failure reason:

Has the patient undergone splenectomy? ☐ Yes ☐ No

☐ **Chronic Hepatitis C Associated Thrombocytopenia (Promacta)**

Payment will be considered to allow for initiation and/or maintenance of interferon-based therapy with ribavirin when the patient has a baseline platelet count less than 75 x 10^9/L. Requests will not be considered under the following conditions: 1. Patients taking direct acting antiviral agents for the treatment of chronic hepatitis C infection in addition to interferon based therapy with ribavirin. 2. Patients taking direct acting antiviral agents used without interferon for treatment of chronic hepatitis C infection. 3. Patients with decompensated liver disease with a Child-Pugh score > 6 (Class B and C). 4. Patients with a history of ascites. 5. Patients with hepatic encephalopathy.

- Baseline platelet count: _____ Lab Date: _____
- Patient using direct acting antiviral agents without interferon: ☐ Yes ☐ No
- Patient has decompensated liver disease with a Child-Pugh score > 6 (Class B & C): ☐ Yes ☐ No
- Patient has a history of ascites: ☐ Yes ☐ No
- Patient has hepatic encephalopathy: ☐ Yes ☐ No

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☐ **Severe Aplastic Anemia (Promacta)**

Payment will be considered under the following conditions: 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

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

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
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 Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.