Pennsylvania
Department of Human Services

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

THROMBOPOIETICS PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

Prior authorization guidelines for **Thrombopoietics** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html.

☐ 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:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

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

Complete all sections that apply to the beneficiary and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

☐ **For ALL requests:**
- ☐ Has recent results of a CBC with differential
- ☐ Has recent results of liver function tests *(if recommended in the FDA-approved package labeling [e.g., Alvaiz, Promacta, Tavalisse])*

☐ **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 previous treatment. Other treatments tried:
  - ☐ corticosteroids
  - ☐ immune globulin
  - ☐ rituximab
  - ☐ splenectomy

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☐ other: ______________________________

☐ **For treatment of severe aplastic anemia:**
- ☐ Had an insufficient response to immunosuppressive therapy
- ☐ Will be used in combination with standard immunosuppressive therapy as first-line treatment
- ☐ Has one of the following:
  - ☐ marrow cellularity <25%
  - ☐ marrow cellularity 25-50% with <30% residual hematopoietic cells
- ☐ Has two of the following:
  - ☐ neutrophil count $<0.5 \times 10^9$/L
  - ☐ platelet count $<20 \times 10^9$/L
  - ☐ reticulocyte count $<60 \times 10^9$/L (using an automated reticulocyte count)

☐ **For treatment of thrombocytopenia with chronic hepatitis C virus infection:**
- ☐ Is or will be receiving interferon therapy
- ☐ Has a pretreatment platelet count $<30 \times 10^9$/L

☐ **For all other indications:**
- ☐ Has a pretreatment platelet count $<30 \times 10^9$/L

☐ **For a NON-PREFERRED Thrombopoietic:**
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Thrombopoietics that are approved or medically accepted for treatment of the beneficiary's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

RENEWAL requests

☐ **For ALL requests:**
- ☐ Has recent results of a CBC with differential
- ☐ Has recent results of liver function tests *(if recommended in the FDA-approved package labeling [e.g., Alvaiz, Promacta, Tavalisse])*

☐ **For treatment of severe aplastic anemia:**
- ☐ Experienced a positive clinical response since starting the requested drug

☐ **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:

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