P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth

PREAUTHORIZATION FORM

Nplate™ and Promacta®
(romiplostim and eltrombopag)

Therapeutic use: Treatment of thrombocytopenia in patients with chronic immune thrombocytopenic purpura (ITP).

Quantity Limit:

- Initial dosing:
  - Nplate: 1mcg/kg once weekly as a subcutaneous injection
  - Promacta: 50 mg orally once daily
- Maintenance dosing: To maintain a platelet count ≥50,000/microL
  - Nplate: Adjust weekly dosing by 1mcg/kg, not to exceed 10mcg/kg weekly
  - Promacta: Adjust daily dose by 25mg, not to exceed 75 mg daily

Authorization Period: 6 months

Patient's name _____

Patient's ID# | | | | | | | | | | DOB | | | / | | | / | | | | |

ICD-9 | | | | | | | | | | _____

Physician's name_____

Physician's Ph# (| | |) | | | | - | | | | | Fax# | | | | - | | | | |

Physician's signature_____ Date signed | | | / | | | / | | | | |

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Which medication is being requested? ❑ Nplate ❑ Promacta		
2.	Is the prescribing physician a Hematologist/Oncologist?	❑ Yes	❑ No
3.	Has the patient been diagnosed with chronic immune (idiopathic) thrombocytopenic purpura (ITP)?	❑ Yes	❑ No
4.	Has the patient had an insufficient response to corticosteroids, immunoglobulins, or splenectomy?	❑ Yes	❑ No
5.	For initial authorization: Is there evidence of bleeding or platelet count <20,000/microL?	❑ Yes	❑ No
6.	For reauthorization: Is the patient's most recent platelet count >400,000/microL?	❑ Yes	❑ No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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