CONTAINS CONFIDENTIAL PATIENT INFORMATION

Nplate (romiplostim)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Nplate (romiplostim)	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

☐ Yes ☐ No Patient has documentation of a recent trial and therapy failure with a preferred thrombopoietin receptor agonist (Promacta) **If No:**
- ☐ Yes ☐ No Documented evidence is provided that the use of this agent would be medically contraindicated

☐ Yes ☐ No Patient has a diagnosis of chronic immune thrombocytopenic purpura (ITP) **If Yes:**
- ☐ Yes ☐ No Patient has documentation of an insufficient response to a corticosteroid, an immunoglobulin, or the patient has undergone a splenectomy

☐ Yes ☐ No Patient is using for the treatment of chronic hepatitis C associated thrombocytopenia **If Yes:**
- ☐ Yes ☐ No Patient is using for interferon-based therapy with ribavirin and has a baseline platelet count less than 75 x 109 L
- ☐ Yes ☐ No Patient is taking direct acting antiviral agents for the treatment of chronic hepatitis C genotype 1 infection in addition to interferonbased therapy with ribavirin
- ☐ Yes ☐ No Patient is taking direct acting antiviral agents used without interferon for treatment of chronic hepatitis C infection
- ☐ 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

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Patient Name: _____ **Patient ID#:** _____

☐ Yes ☐ No Patient is using for the treatment of severe aplastic anemia **If Yes:**

- ☐ Yes ☐ No Patient has documentation of an insufficient response or intolerance to at least one prior immunosuppressive therapy
- ☐ Yes ☐ No Patient has a platelet count less than or equal 30 x 109/L
- ☐ Yes ☐ No Request is for continued therapy **If Yes:**
  - ☐ Yes ☐ No Documentation of hematologic response after 16 weeks of therapy is provided

Please Note: Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

9. PHYSICIAN SIGNATURE

_____ _____

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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