







An Anthem Company

CONTAINS CONFIDENTIAL PATIENT INFORMATION Promacta (eltromobopag) 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 INFO	RMATION			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 Add	ress:			Physician DEA:					
				Physician NPI #:					
				Physician Email Address					
3. MEDICATION		4. 3	STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS				
Promacta (eltromobopag)					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 ha	s a dia	agnosis of chronic immu	ne thrombocytopenic purpu	Ira (ITP) If Yes:				
			Patient has documenta	tion of an insufficient respon patient has undergone a sp	nse to a corticosteroid, an				
□ Yes □ No	Patient is u	usina	•	nic hepatitis C associated th	-				
		I No		rferon-based therapy with ri	ibavirin and has a baseline platelet				
		I No	Patient is taking direct		e treatment of chronic hepatitis C				
		I No	• •	acting antiviral agents used	without interferon for treatment of				
	□ Yes □	I No	•		hild-Pugh score > 6 (Class B & C)				
		I No	Patient has a history of		÷ , , ,				
	□ Yes □	I No	Patient has hepatic end	cephalopathy					

 \Box Yes \Box 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.

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Authonization of Benefits Center at 1-844-512-9

Provider Help Desk 1-800-454-3730

Patient Name:

Patient ID#:

9. PHYSICIAN SIGNATURE

Prescriber or Authorized Signature
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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