



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

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

9. PHYSICIAN SIGNATURE

Prescriber or Authorized Signature	Date
<i>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.</i>	
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.	
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