Health Partners •••• Medicare

PRIOR AUTHORIZATION REQUEST FORM

Promacta - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.	
Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):
REQUEST FOR EXPEDITED REVIEW: By checking this box and sign the life or health of the enrollee or the enrollee's ability to regain materials.	gning below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize aximum function.
Drug Name:	
Strength:	
Directions / SIG:	
Please attach any pertinent medical history inc	cluding labs and information for this member that may support approval.
	wer the following questions and sign.
Q1. Does the patient have the diagnosis of thro (ITP)?	mbocytopenia in a patient with chronic immune thrombocytopenia
Yes	□ No
Q2. Is the patient 1 year of age or older?	
Yes	□ No
Q3. Has the patient had an inadequate respons dexamethasone, or methylprednisolone), immur	ee, intolerance or contraindication to glucocorticoids (prednisone, noglobulins, or splenectomy?
Yes	□ No
Q4. Des the patient have the diagnosis of throm	nbocytopenia in a patient with chronic hepatitis C?
Yes	□ No
Q5. Is the patient 18 years of age or older?	
Yes	□ No
Q6. Has the patient's degree of thrombocytoper ability to maintain interferon-based therapy?	nia prevented the initiation of interferon-based therapy or limited the
Yes	□ No
Q7. Does the patient have the diagnosis of seve	ere aplastic anemia?
Yes	□ No
The state of the s	

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Patient Name:	Prescriber Name:
Q8. Is the patient 2 years of age or older?	
☐ Yes	□ No
Q9. Has the patient had an inadequate response, intoleral Promacta be used in combination with standard immunos	nnce or contraindication to immunosuppressive therapy, or will suppressive therapy?
☐ Yes	□ No
Q10. Is Promacta being prescribed by or in consultation v	vith a hematologist?
☐ Yes	□ No
Q11. Is Promacta being prescribed by or in consultation v specialist?	vith a hematologist, hepatologist, or infectious disease
☐ Yes	□ No
Q12. Additional Information:	
Q13. Duration:	
☐ 12 months	Other:
Prescriber Signature	Date
	2023 Medicare Prior Authorization Request