US Family Health Plan

Prior Authorization Request Form for

Eltrombopag (Alvaiz)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. What is the indication or diagnosis?	☐ Immune thrombocytopenia - Proceed to question **2** ☐ Thrombocytopenia with chronic Hepatitis C - Proceed to question **11** ☐ Aplastic anemia - Proceed to question **15** ☐ Other - **STOP Coverage not approved**	
2. Is the patient 6 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication prescribed by or in consultation with a hematologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a platelet count less than 30 x 10^9 /L (less than 30,000/mcL)?	☐ Yes Proceed to question **7**	☐ No Proceed to question **5**
5. Does the patient have a platelet count less than 50 x 10^9 /L (less than 50,000/mcL)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**

6. According to the prescriber, is the patient at an increased risk for bleeding?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed Nplate or Promacta?	☐ Yes Proceed to question **10**	☐ No Proceed to question **8**
8. Does the patient have a contraindication to both NPlate and Promacta?	☐ Yes Proceed to question **10**	☐ No Proceed to question **9**
9. Does the patient expect to have an adverse effect to both Nplate and Promacta that would not be anticipated with the requested medication?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Is the requested medication being used at the same time with other chronic ITP therapy?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
11. Is the patient 18 years of age or older?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the requested medication prescribed by or in consultation with a gastroenterologist, a hepatologist, or a physician who specializes in infectious disease?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does the patient have low platelet counts (less than 75,000/mcL) at baseline?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Will the patient be receiving interferon-based therapy for chronic hepatitis C?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
15. Is the patient 18 years of age or older?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Is the requested medication prescribed by or in consultation with a hematologist?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**

17. Does the patient have low platelet counts (less than 30,000/mcL) at baseline?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Had the patient tried at least one immunosuppressant therapy (cyclosporine, mycophenolate mofetil, or sirolimus)?	☐ Yes **Sign and date below**	☐ No Proceed to question **19**
19. Will the patient be using the requested medication in combination with standard immunosuppressive therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____