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	ient Name: ient ID:		Detient Date Of Dinth.		8/12/2024				
	ient Group No:	Patient Date Of Birth: Patient Phone: NPI#:		Phy Spe Phy	Telephone				
Phy	ysician Office Address:								
Dru	g Name (specify drug)	<del>-</del>							
	antity:	• •							
	ute of Administration: gnosis:		<ul><li>Expected Length of Therapy:</li><li>ICD Code:</li></ul>						
Cor									
Ple 1.	Will the requested drug	te answer for each applica be used concurrently with or Mulpleta) or with spleen tyro	ble question. ther thrombopoietin receptor agonist sine kinase inhibitors (e.g., Tavalisso	ts Y e)?	_	N			
2.	What is the prescribed p								
	Promacta (If checked	, go to 3)							
	Alvaiz (If checked, go	to 4)							
3.	What is the diagnosis?  Persistent or chronic is	immune thrombocytopenia (	ITP) (If checked, go to 5)						
	Thrombocytopenia as	sociated with chronic hepat	itis C (If checked, go to 15)						
	Aplastic anemia (If ch	ecked, go to 20)							
	Myelodysplastic synd	romes (If checked, go to 32)							
	MYH9-related disease	e with thrombocytopenia (If o	checked, go to 36)						
	Chemotherapy-induce	ed thrombocytopenia (CIT) (	If checked, go to 37)						
		. (If checked, no further ques							
4.	What is the diagnosis? Persistent or chronic	immune thrombocytopenia (	ITP) (If checked, go to 5)						
	Thrombocytopenia as	sociated with chronic hepat	itis C (If checked, go to 15)						
	Aplastic anemia (If ch	ecked, go to 20)							
	Chemotherapy-induce	ed thrombocytopenia (CIT) (	If checked, go to 37)						
	Other, please specify.	. (If checked, no further ques	stions)						
5.	Is the requested drug be oncologist?	eing prescribed by or in cons	sultation with a hematologist or	Y		N			
6	Is the request for continu	uation of therapy with Proma	acta or Alvaiz?		, _				

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7.	Is the patient currently receiving Promacta or Alvaiz through samples or a manufacturer's patient assistance program?			
	Yes (If checked, go to 8)			
	No (If checked, go to 11)			
	Unknown (If checked, go to 8)			
8.	Has the patient had an inadequate response or intolerance to corticosteroids, immunoglobulins, or splenectomy?	Υ	N	
9.	What is/was the lowest untransfused platelet count at any point prior to the initiation of Promacta or Alvaiz? ACTION REQUIRED: Attach laboratory documentation or chart notes with untransfused platelet count prior to the initiation of immune thrombocytopenia (ITP) therapy.			
	Less than 30,000/mcL (30x10^9/L) (If checked, no further questions)			
	30,000/mcL to 50,000/mcL (30x10^9/L to 50x10^9/L) (If checked, go to 10)			
	Greater than 50,000/mcL (50x10^9/L) (If checked, no further questions)			
	Unknown (If checked, no further questions)			
	ACTION REQUIRED: Submit supporting documentation			
10.	Does the patient have symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma) or risk factors for bleeding? Examples of risk factors (not all inclusive): a) Undergoing a medical or dental procedure where blood loss is anticipated, b) Comorbidity (e.g., peptic ulcer disease, hypertension), c) Mandated anticoagulation therapy, d) Profession (e.g., construction worker) or lifestyle (e.g., plays contact sports) that predisposes patient to trauma.	Y	N	
11.	What is the patient's current platelet count? ACTION REQUIRED: Attach laboratory documentation or chart notes with current platelet count.			
	Less than 50,000/mcL (50x10^9/L) (If checked, go to 12)			
	50,000/mcL to 200,000/mcL (50x10^9/L to 200x10^9/L) (If checked, no further questions)			
	Greater than 200,000/mcL (200x10^9/L) to less than or equal to 400,000/mcL (400x10^9/L) (If checked, go to 14)			
	Greater than 400,000/mcL (400x10^9/L) (If checked, no further questions)			
	Unknown (If checked, no further questions)			
	ACTION REQUIRED: Submit supporting documentation			
12.	Is the platelet count sufficient to prevent clinically important bleeding?	Υ	N	
13.	Has the patient received a maximal dose of the requested drug for at least 4 weeks?	Y	N	
14.	Will dosing be adjusted to achieve a platelet count sufficient to avoid clinically important bleeding?	Υ	N	
15.	Will the requested drug be prescribed by or in consultation with a prescriber specializing in one of the following: A) infectious disease, B) gastroenterology, C) hepatology, or D) transplant?	Y	N	
16.	Is the request for continuation of therapy with Promacta or Alvaiz?	Υ	N	
17.	Is the patient currently receiving Promacta or Alvaiz through samples or a manufacturer's patient assistance program?			
	Yes (If checked, go to 18)			
	No (If checked, go to 19)			
	Unknown (If checked, go to 18)			
18.	Will Promacta or Alvaiz be used to initiate and maintain interferon-based therapy?	Υ	N	

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19.	Is the patient still receiving interferon-based therapy?	Y		N	
20.	Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?	Y		N	
21.	Is the request for continuation of therapy with Promacta or Alvaiz?	Y		N	
22.	Is the patient currently receiving Promacta or Alvaiz through samples or a manufacturer's patient assistance program?				
	Yes (If checked, go to 23)				
	No (If checked, go to 27)				
	Unknown (If checked, go to 23)				
23.	What is the prescribed product?				
	Promacta (If checked, go to 24)				
	Alvaiz (If checked, go to 26)				
24.	Will Promacta be used as first-line treatment of severe aplastic anemia?	Y		N	
25.	Will Promacta be used in combination with standard immunosuppressive therapy (e.g., horse antithymocyte globulin [h-ATG] and cyclosporine)?	Y		N	
26.	Has the patient had an insufficient response to immunosuppressive therapy?	Y		N	
27.	What is the patient's current platelet count? ACTION REQUIRED: Attach laboratory documentation or chart notes with current platelet count.				
	Less than 50,000/mcL (50x10^9/L) (If checked, go to 28)				
	50,000/mcL to 200,000/mcL (50x10^9/L to 200x10^9/L) (If checked, no further questions)				
	Greater than 200,000/mcL (200x10^9/L) to less than or equal to 400,000/mcL (400x10^9/L) (If checked, go to 31)				
	Greater than 400,000/mcL (400x10^9/L) (If checked, no further questions)				
	Unknown (If checked, no further questions)				
	ACTION REQUIRED: Submit supporting documentation				
28.	Is the patient transfusion-independent?	Y		N	
29.	Has the patient received appropriately titrated therapy for at least 16 weeks?	Y		N	
30.	How many weeks of therapy has the patient received? (If less than 16 weeks received, please provide how many weeks of therapy the patient has received.)		_		
	Less than 16 weeks (If checked, no further questions)		Ш		
	16 weeks or more (If checked, no further questions)				
31.	Will dosing be adjusted to achieve and maintain an appropriate target platelet count?	Y		N	
32.	Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?	Y		N	
33.	Is the request for continuation of therapy with Promacta?	Y		N	
34.	Is the patient currently receiving Promacta through samples or a manufacturer's patient assistance program?				
	Yes (If checked, no further questions)				
	No (If checked, go to 35)				

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	Unknown (If checked, no further questions)			
35.	Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)?	Y	N	
36.	Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?	Υ	N	
37.	Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?	Y	N	
38.	Is the request for continuation of therapy with Promacta or Alvaiz?	Y	N	
39.	Is the patient currently receiving Promacta or Alvaiz through samples or a manufacturer's patient assistance program?			
	Yes (If checked, go to 40)			
	No (If checked, go to 42)			
	Unknown (If checked, go to 40)			
40.	Does the patient have prolonged thrombocytopenia?	Υ	N	
41.	Is the patient post-allogenic transplant and has poor graft function?	Y	N	
42.	Has the patient experienced benefit from therapy (e.g., increased platelet counts, decreased bleeding events, reduced need for platelet transfusions)?	Y	N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

## Prescriber (Or Authorized) Signature and Date

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