BlueCross BlueShield Federal Employee Program

ALVAIZ / PROMACTA PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		

PHYSICIAN COMPLETES

NOTE: Form must be completed in its **entirety** for processing

Please select medication: ❑**Alvaiz (eltrombopag)** ❑**Promacta (eltrombopag)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?
   - ❑Chronic or persistent immune (idiopathic) thrombocytopenia (ITP) ❑Severe aplastic anemia
   - ❑Thrombocytopenia associated with chronic hepatitis C
   - ❑Other ***(please specify)***: _____
2. Will this medication be used in combination with another thrombopoietin receptor agonist or with Tavalisse (fostamatinib disodium hexahydrate)? ❑Yes* ❑No
   - ****If YES***, please specify the medication: _____
3. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Does the prescriber agree to obtain baseline clinical hematology and liver function tests and to monitor during treatment? ❑Yes ❑No

b. **Chronic or Persistent Immune ITP Diagnosis**: **Please answer the following questions**:

i. Has the patient had a splenectomy? ❑Yes ❑No*

If NO, does the patient have an intolerance or have they had an inadequate treatment response to corticosteroids or immunoglobulins? ❑Yes ❑No

ii. Was the patient's platelet count less than 50,000 per microliter (mcL) at the time of diagnosis? ❑Yes ❑No

c. **Severe Aplastic Anemia Diagnosis**: **Please answer the following questions**:

i. **Promacta Request**: Is this medication being used as first line therapy in combination with standard immunosuppressive therapy? ❑Yes ❑No

ii. **Age 18 or Older**: Has the patient had an inadequate response to immunosuppressive therapy? ❑Yes ❑No

iii. Was the patient's platelet count less than 50,000 per microliter (mcL) at the time of diagnosis? ❑Yes ❑No

d. **Thrombocytopenia associated with chronic hepatitis** C **Diagnosis**: **Please answer the following questions**:

i. Is this medication being used to initiate and maintain interferon-based therapy? ❑Yes ❑No

ii. Was the patient's platelet count less than 75,000 per microliter (mcL) at the time of diagnosis? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. What is the patient's current platelet count? _____ platelets per microliter (mcL)

b. **If platelet count is 200,000 to 400,000 platelets/mcL**: Does the prescriber agree to adjust therapy to the minimum platelet count needed to reduce the bleeding risk? ❑Yes ❑No

c. Does the prescriber agree to measure clinical hematology and liver function tests during treatment? ❑Yes ❑No

d. Are the patient's ALT counts less than 3 times the upper limits of normal? ❑Yes ❑No

e. **Promacta Request, Age 2-17, Severe Aplastic Anemia Diagnosis**: Is this medication being used in combination with standard immunosuppressive therapy? ❑Yes ❑No

f. **Thrombocytopenia associated with chronic hepatitis C Diagnosis**: Is this medication being used to maintain interferon-based therapy? ❑Yes ❑No