GHP Family Pharmacy Customer Service
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Geisinger

THROMBOPOIETICS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Thrombopoietics** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐Renewal request	Total # of pages: ______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Weight:
Dose/directions:	Quantity:	Duration:
Diagnosis (*submit documentation*):	DX code (*required*):	

INITIAL requests

For a non-preferred Thrombopoietic: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class listed above that are approved or medically accepted for treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.*	☐Yes ☐No	*Submit documentation.*

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

- ☐Has recent results of a CBC with differential
- ☐Has recent results of liver function tests
- ☐**For treatment of thrombocytopenia prior to a procedure:** Planned procedure date:____________ Planned administration date: ____________
  - ☐Has chronic liver disease
  - ☐Has a pretreatment platelet count < 50 x 10^9/L
- ☐**For treatment of immune thrombocytopenia:** Duration of thrombocytopenia: ______________________________
  - ☐Has a pretreatment platelet count < 30 x 10^9/L
  - ☐Had an insufficient response to corticosteroids, immunoglobulin, and/or splenectomy
- ☐**For treatment of severe aplastic anemia:**
  - ☐Had an insufficient response to immunosuppressive therapy
  - ☐Has a pretreatment platelet count < 30 x 10^9/L
  - ☐Will be used in combination with standard immunosuppressive therapy as first-line treatment
- ☐**For treatment of thrombocytopenia with chronic hepatitis C virus infection:**
  - ☐Is or will be receiving interferon therapy

RENEWAL requests

Complete the sections below that are applicable to the beneficiary and this request and SUBMITDOCUMENTATION for each item.

- ☐Has recent results of a CBC with differential
- ☐Has recent results of liver function tests
- ☐**For treatment of severe aplastic anemia:**
  - ☐Experienced a positive clinical response since starting the requested medication
- ☐**For all treatment of all other conditions:**
  - ☐Platelet count increased to a level sufficient to avoid bleeding that requires medical attention

Please submit to PromptPA **https://ghp.promptpa.com** OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date:

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