Print Reset

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATIONS ALVAIZ™ (eltrombopag choline) AND PROMACTA® (eltrombopag olamine)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

PROMACTA® (eltrombopag olamine): To receive a one-year approval, answer these questions:

1. Is the member 1 year of age or older with a diagnosis of thrombocytopenia with persistent or chronic immune thrombocytopenia (ITP) who has had an insufficient response to corticosteroids, immunoglobulins, or splenectomy? **OR**

   ☐ Yes ☐ No

   If yes, list past failures:

2. Is the member being treated for thrombocytopenia with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy? **OR**

   ☐ Yes ☐ No

3. Is the member 2 years of age or older with Promacta® being used in combination with standard immunosuppressive therapy (IST) for the first-line treatment of severe aplastic anemia? **OR**

   ☐ Yes ☐ No

4. Is the member being treated for severe aplastic anemia and has the member had an insufficient response to immunosuppressive therapy? **AND**

   ☐ Yes ☐ No

5. Will the prescriber assess the member's liver function prior to therapy initiation and periodically during therapy as recommended in the product label?

   ☐ Yes ☐ No

6. Has the member had a baseline ocular exam prior to therapy?

   ☐ Yes ☐ No

7. Will sexually active individuals of reproductive potential use effective contraception during treatment and for at least 7 days after stopping treatment?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

ALVAIZ™ (eltrombopag choline): To receive a one-year approval, answer these questions:

8. Is the member 6 years of age or older with a diagnosis of thrombocytopenia with persistent or chronic immune thrombocytopenia (ITP) who has had an insufficient response to corticosteroids, immunoglobulins, or splenectomy? **OR**

   ☐ Yes ☐ No

   If yes, list past failures:

   _____

9. Is the member an adult and being treated for thrombocytopenia with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy? **OR**

   ☐ Yes ☐ No

10. Is the member an adult and being treated for severe aplastic anemia and has the member had an insufficient response to immunosuppressive therapy? **AND**

    ☐ Yes ☐ No

11. Will the prescriber assess the member's liver function prior to therapy initiation and periodically during therapy as recommended in the product label?

    ☐ Yes ☐ No

12. Has the member had a baseline ocular exam prior to therapy?

    ☐ Yes ☐ No

13. Will sexually active individuals of reproductive potential use effective contraception during treatment and for at least 7 days after stopping treatment?

    ☐ Yes ☐ No

For renewal, complete the following questions to receive a 1-year approval:

14. Does the member continue to meet the above criteria? **AND**
    ☐ Yes ☐ No
15. Does the member continue to experience clinical benefit from the requested treatment? **AND**
    ☐ Yes ☐ No
16. Is the member free from unacceptable toxicity?
    ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.