Promacta (eltrombopag)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard
☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:

☐ Promacta 12.5mg suspension packet
☐ Promacta 25mg suspension packet
☐ Promacta 25mg tablet
☐ Promacta 50mg tablet
☐ Promacta 75mg tablet

Dose and Quantity: Duration of therapy: J-Code: ICD10:

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other *(please specify)*:
☐ Retail pharmacy
☐ Home Health/Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):
Is this infusion occurring in a facility affiliated with hospital outpatient setting? Yes ☐ No ☐
If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? Yes ☐ No ☐
NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting.

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis:
☐ chronic immune (idiopathic) thrombocytopenia (ITP)
☐ thrombocytopenia in individuals with Myelodysplastic Syndrome (MDS)
☐ other *(please specify)*:
☐ thrombocytopenia with chronic hepatitis C
☐ severe aplastic anemia

Clinical Information:
Is this a new start of therapy or continuation of therapy? If your patient has already begun treatment with drug samples, please choose "new start of therapy". ☐ new start ☐ continued therapy

(if continued therapy) Is there documentation that your patient's platelet counts have increased since starting this drug? Yes ☐ No ☐
(if continued therapy) Is your patient still at risk for bleeding complications? Yes ☐ No ☐
(if no to either question) Please provide clinical support for the continued use of this drug.

(if MDS) Does your patient have low-risk to intermediate-risk MDS (for example: IPSS-R score greater than 1.5 to 4.5 points)? Yes ☐ No ☐

(if ITP/MDS) Prior to starting the requested drug, what is/was your patient's platelet count?
☐ 50,000 cells/mm3 or higher
☐ 30,000 to 49,999 cells/mm3
☐ 29,999 cells/mm3 or less
☐ unknown
(if 30,000 to 49,999 cells/mm3) Prior to starting this drug, is/was your patient at a higher risk for bleeding due to their clinical condition (for example: concurrent use of anticoagulants, cerebrovascular disease, chemotherapy)? Yes ☐ No ☐

(if ITP) Has your patient had an inadequate response to, or is not a candidate for, an initial treatment option (for example, corticosteroids, immunoglobulins, rituximab, splenectomy)? Yes ☐ No ☐

(if hep C) Prior to starting this drug, is/was your patient's platelet count less than 75,000 cells/mm3? Yes ☐ No ☐
(if hep C) Is/was the thrombocytopenia preventing your patient from starting or staying on interferon-based therapy for chronic hepatitis C? Yes ☐ No ☐

Additional Pertinent Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:________________________________ **Date:**________________

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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