Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Thrombopoietics

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. The request is for a Thrombopoietic that was previously approved. If YES, go to 8.

☐ Yes ☐ No

Q2. The member meets BOTH of the following:

☐ Is prescribed the Thrombopoietic for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication

☐ Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Is prescribed the Thrombopoietic by or in consultation with an appropriate specialist (i.e., hematologist/oncologist, gastroenterologist, hepatologist, etc.)

Q3. For treatment of thrombocytopenia prior to a procedure, both of the following:

☐ Has a pretreatment platelet count <50 x 109/L

☐ Will begin treatment with the requested Thrombopoietic prior to the scheduled procedure in accordance with FDA-approved package labeling

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Member Name:	Prescriber Name:

Q4. For treatment of severe aplastic anemia, has marrow cellularity <25% (or 25%-50% with <30% residual haematopoietic cells).

☐ Yes ☐ No

Q5. The member meets TWO of the following:

☐ Neutrophil count <0.5 109/L
☐ Platelet count <20 109/L
☐ Reticulocyte count <60 109/L (using an automated reticulocyte count)

Q6. For treatment of other indications, ONE of the following:

☐ Has a pretreatment platelet count <30 x 109/L

☐ Use is supported by the NCCN Drugs & Biologics Compendium, nationally recognized compendia, or peer-reviewed medical literature

Q7. Has documentation of baseline lab results and monitoring as recommended in the FDA-approved package labeling.

☐ Yes ☐ No

Q8. For a non-preferred Thrombopoietic, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Thrombopoietics approved or medically accepted for the beneficiary's indication. See the Preferred Drug List for the list of preferred Thrombopoietics at: https://papdl.com/preferred-drug-list.

☐ Yes ☐ No

Q9. The member meets BOTH of the following:

☐ Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Is prescribed the Thrombopoietic by or in consultation with an appropriate specialist (i.e., hematologist/oncologist, gastroenterologist, hepatologist, etc.)

Q10. The member meets ONE of the following:

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Member Name:	Prescriber Name:

☐ For treatment of severe aplastic anemia, has documentation of a positive clinical response	☐ For treatment of all other diagnoses, has an increased platelet count sufficient to avoid bleeding that requires medical attention

Q11. Has documentation of repeat lab results and monitoring as recommended in the FDA-approved package labeling.

☐ Yes ☐ No

Q12. Additional Information:

_____ _____

Prescriber Signature Date

v2026-06