



THROMBOPOIETICS PRIOR AUTHORIZATION FORM (form effective 1/5/2026)

Prior authorization guidelines for **Thrombopoietics** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

<input type="checkbox"/> New request	<input type="checkbox"/> 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:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	Weight:
Dose/directions:	Quantity:	Duration:
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):	

Complete all sections that apply to the beneficiary and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

1. ALL requests:

- Has recent results of a CBC with differential
- Has recent results of liver function tests if recommended in the FDA-approved package labeling

2. 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 10⁹/L

3. For treatment of IMMUNE THROMBOCYTOPENIA:

Duration of thrombocytopenia: _____

- Has a pretreatment platelet count <30 x 10⁹/L
- Had an insufficient response to corticosteroids, immunoglobulin, or splenectomy
- Had an insufficient response to other previous therapy(ies) for thrombocytopenia – specify: _____



4. For treatment of SEVERE APLASTIC ANEMIA:

- ONE of the following:
 - Has marrow cellularity <25%
 - Has marrow cellularity ≥25% and ≤50% with <30% residual hematopoietic cells
- TWO of the following:
 - Neutrophil count <0.5 x 10⁹/L
 - Platelet count <20 x 10⁹/L
 - Reticulocyte count <60 x 10⁹/L (using automated reticulocyte count)
- Will be used in combination with standard immunosuppressive therapy as first-line treatment
- Had an insufficient response to immunosuppressive therapy

5. For treatment of THROMBOCYTOPENIA WITH CHRONIC HEPATITIS C VIRUS INFECTION:

- Is or will be receiving interferon therapy

6. For treatment of ALL OTHER conditions, at least ONE of the following:

- Has a pretreatment platelet count <30 x 10⁹/L
- Use is supported by the NCCN Drugs and Biologics Compendium, nationally recognized compendia, or peer-reviewed medical literature

7. For a NON-PREFERRED Thrombopoietic:

- Tried and failed or has a contraindication or an intolerance to the preferred Thrombopoietics (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.)

RENEWAL requests

1. ALL requests:

- Has recent results of a CBC with differential
- Has recent results of liver function tests if recommended in the FDA-approved package labeling

2. For treatment of SEVERE APLASTIC ANEMIA:

- Experienced a positive clinical response since starting the requested medication

3. For all treatment of ALL OTHER CONDITIONS:

- Platelet count increased to a level sufficient to avoid bleeding that requires medical attention

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:

Date:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.