Updated: 05/2021
DMMA Approved: 05/2021

Request for Prior Authorization for Tavalisse (fostamatinib)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Tavalisse (fostamatinib) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Tavalisse (fostamatinib) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of Chronic Immune Thrombocytopenia (ITP) and the following criteria is met:

- Must be at least 18 years old
- Must provide documentation of platelet count ≤ 30,000/μL (30 x 10^9/L)
- Must be prescribed by or in consultation with a hematologist or oncologist
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to ONE of the following:
  - Four-day trial of corticosteroid therapy
  - Immunoglobulins*
  - Thrombopoietin receptor agonist (ie. Promacta, Nplate)*
  - Splenectomy
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - Documentation that member is responding positively to therapy by providing ONE of the following since starting therapy:
    - Increase in platelet count
    - Reduction in bleeding events
- **Reauthorization Duration of approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

*Immunoglobulins and Thrombopoietin receptor agonists may require a prior authorization.

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TAVALISSE (FOSTAMATINIB) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Health Options ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

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

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Does the member have a platelet count ≤ 30,000/µL? ☐ Yes, level: _____, date:_____ ☐ No

Which of the following have been tried? *(please list below with additional information)*

- ☐ At least 4-day course of corticosteroids
- ☐ Immunoglobulins
- ☐ Thrombopoietin receptor agonist (ie.Promacta, Nplate)
- ☐ Splenectomy

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member responded positively to therapy? ☐ Yes ☐ No

If yes, please indicate what improvements have been experienced since starting therapy (check all that apply):

- ☐ Increase in platelet count
- ☐ Reduction in bleeding events

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date