Updated: 09/2018
PARP Approved: 09/2018

Prior Authorization Criteria

Tavalisse (fostamatinib)

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

For all requests for Tavalisse (fostamatinib) all of the following criteria must be met:

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

- Member is 18 years of age or older.
- Must provide documentation of platelet count ≤ 30,000/μL
- Medication must be prescribed by or in consultation with a hematologist.
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to ALL the following:
    - Four-day trial of corticosteroid therapy
    - IVIG* therapy
    - 60-day trial of either Promacta* or Nplate*
- Member has relapsed after splenectomy, or has a contraindication to 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**
    - Must provide documentation that member is responding positively to therapy by providing ONE of the following:
        - 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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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 Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
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 (if medically please provide a 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)

- Is member 18 years of age or older?
  ☐ Yes ☐ No
- Is there documentation of platelet count ≤ 30,000/μL?
  ☐ Yes ☐ No
- Will the medication be prescribed by or in consultation with a hematologist?
  ☐ Yes ☐ No
- Is there documentation showing the member has tried and failed or had an intolerance or contraindication to ANY of the following:
  a. Four-day trial of corticosteroid therapy
     ☐ Yes ☐ No
  b. IVIG therapy
     ☐ Yes ☐ No
  c. 60-day trial of either Promacta or Nplate
     ☐ Yes ☐ No

- Has the member relapsed after splenectomy, or does the member have a contraindication to splenectomy?
  ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY			
Medication Name	**Strength/ Frequency**	**Dates of Therapy**	**Status (Discontinued & Why/Current)**

Please provide documentation that member is responding positively to therapy by providing ONE of the following:

- Increase in platelet count
- Reduction in bleeding events

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date