Montana Healthcare Programs Prior Authorization Request Form
for Use of Tavalisse (fostamatinib)

Member Name: ___________________________ DOB: ___________ Date: ___________

Member ID: ___________________________ Prescriber Phone/Fax: ___________________________

Prescriber Name: ___________________________ Prescriber Specialty: ___________________________

Requested Dose/Directions: ___________________________

Please complete below information for applicable situation, **Initiation or Continuation** of therapy and attach supporting documentation:

**INITIATION OF THERapy**
1. Member has a diagnosis of chronic immune thrombocytopenia (ITP) □ Yes □ No
2. Medication is being prescribed by or in consultation with a hematologist: □ Yes □ No
3. Member age is ≥18 years old □ Yes □ No
4. Baseline platelet count___________________________ (must be < 30 x 109/L) Date: _______________
5. Member has had an inadequate response or is intolerant to at least two of the following therapies (circle):
   - Corticosteroids OR immunoglobulins OR thrombopoietin-receptor agonist (TPO-RA) OR rituximab OR splenectomy
6. Monitoring Requirements (provider attests to baseline testing and the following):
   - □ Hematology (CBC including platelet counts/ANC)-at least monthly
   - □ Liver function tests-at least monthly
   - □ Blood pressure-every 2 weeks until stable, then at least monthly
7. Female member? □ Yes □ No If yes, complete the following due to drug potential for fetal harm:
   - Pregnancy status verified □ Yes □ No, member not of reproductive potential
   - Contraceptive counseling provided if reproductive potential exists: □ Yes □ No

LIMITATIONS: Max total daily dose allowed is 300 mg.

**Initial authorization will be issued for 6 months.**

**CONTINUATION OF THERAPY**
- Current platelet count: ______________ (must be > 50 x 109/L) Date: ___________ [attach last 6 months]
- Member has experienced a reduction in clinically significant bleeds □ Yes □ No [attach supporting documents]
- Monitoring requirements as above in #6 will be continued □ Yes □ No

**Reauthorization will be issued for 6 months.**

Please complete form, including required attachments, and fax to:
Drug Prior Authorization Unit at 1-800-294-1350

01/2020