Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
P.O. Box 5119, Helena, MT 59604
Phone 406.443.6002 . Toll-Free 1.800.395.7961
Fax 406.513.1928 . Toll-Free 1.800.294.1350

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 10^9/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 thrombopoetin-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 10^9/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