SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Tavalisse® (fostamatinib)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Medical notes must be submitted to support each line checked on this request.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 3 months

- ❑ The requesting provider is a hematologist, or has been in consultation with one

AND

- ❑ Member is ≥ 18 years of age

AND

- ❑ The member must have a diagnosis of Chronic Immune Thrombocytopenia (ITP), refractory after previous treatment for 6 months or greater

AND

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- ❑ Documentation of platelet levels within the last 30 days has been submitted confirming < 30 x 10^9/L

  [**NOTE:** therapy will be discontinued after 12 weeks if platelet count does not increase to sufficient level]

AND

- ❑ Member must have failed a first-line therapy option with a corticosteroid such as prednisone 0.5-2.0 mg/kg per day:

  DRUG/DOSE: _____ Dates of therapy: _____

AND

- ❑ Documented failure of one other subsequent therapy:
  - ❑ IVIG (accepted if taken in combination with corticosteroids)
  - ❑ Rituximab
  - ❑ Splenectomy
  - ❑ Other: _____

AND

- ❑ Member must have failed **one (1)** of the following therapies: Promacta (eltrombopag) or Nplate (romiplostim) **(will require different prior authorization form)**

Reauthorization Approval: 6 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ The member is not experiencing unacceptable toxicity from the drug (e.g., diarrhea, liver toxicity, hypertension, neutropenia)

AND

- ❑ Clinical hematology laboratory tests and liver function tests have been monitored regularly and the most recent results are submitted **[Laboratory values for platelet count is required to be attached to request (i.e., drawn within the previous 28 days)]**

AND

- ❑ A platelet count of at least 50 × 10^9/L has been achieved and maintained, and at the lowest possible dose

  [**NOTE:** therapy will be discontinued after 12 weeks if platelet count does not increase to sufficient level]

AND

- ❑ Ongoing therapy will not be in combination with another thrombopoietin receptor agonist

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Medication being provided by (check applicable box below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pha rmacy paid claims or submitted chart notes.****