PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Tavalisse - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Tavalisse - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Tavalisse (fostamatinib)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: ______________________
Patient ID: ______________________
Patient Group No.: ______________________
Patient DOB: ______________________
Patient Phone:

Prescribing Physician
Physician Name: ______________________
Physician Phone: ______________________
Physician Fax: ______________________
Physician Address: ______________________
City, State, Zip: ______________________

Diagnosis: ______________________ **ICD Code:** ______________________

Comments: ______________________

Please circle the appropriate answer for each question.

1.	Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	Y N
	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
	[If no, skip to question 5.]	
2.	Has the patient's platelet count increased to greater than or equal to 50 x 10^9/L in response to Tavalisse?	Y N

	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
3.	Is the prescriber monitoring the patient's liver enzymes, CBC, and blood pressure routinely during therapy?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
4.	Is the requested dose less than or equal to the maximum recommended dose?	Y N	
	[No further questions.]		
5.	Does the patient have a documented diagnosis of chronic immune idiopathic thrombocytopenia (ITP) with platelet count less than 30 x 10^9/L?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
6.	Has the patient had an insufficient response to TWO of the following therapies: corticosteroids, immunoglobulin, splenectomy, thrombopoietin receptor agonists (Nplate or Promacta)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
7.	Is the patient 18 years of age or older?	Y N	
	[If no, no further questions.]		
8.	Is the requested dose less than or equal to the maximum recommended dose?	Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date