Prior Authorization Request Form for
fostamatinib (Tavalisse)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2

Please complete clinical assessment:

1. Is there evidence that the patient has active or chronic infection?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **2**
2. Is there evidence of secondary thrombocytopenia?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Has the patient had a cardiovascular event (including but not limited to MI, unstable angina, PE, CVA, and/or NYHA Stage III or IV CHF) within the last 6 months?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. Is there evidence of neutropenia or lymphocytopenia?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **5**
5. Is the requested medication being prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **6**	☐ No **STOP** **STOP** **Coverage not approved**
6. Is this request for initial or continuation of therapy?	☐ Initial proceed to question **7**	☐ Continuation proceed to question **12**
7. Is the patient greater or equal to 18 years of age?	☐ Yes proceed to question 8	☐ No **STOP** **Coverage not approved**
8. Does the patient have a diagnosis of chronic primary idiopathic thrombocytopenic purpura (ITP) whose disease has been refractory to at least one previous therapy (including IVIG, thrombopoietin(s), corticosteroids, and/or splenectomy)?	☐ Yes proceed to question 9	☐ No **STOP** **Coverage not approved**

Prior Authorization Request Form for
fostamatinib (Tavalisse)

9. Does the patient have laboratory evidence of thrombocytopenia with average [platelet] count less than 30 x 10^9/L over three discrete tests?	☐ Yes proceed to question 10	☐ No **STOP** **Coverage not approved**
10. Does the patient have uncontrolled hypertension?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question 11
11. Will the requested medication be used concomitantly with other chronic ITP therapy?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
12. Has the patient demonstrated a response to fostamatinib (Tavalisse) as defined by a sustained platelet count greater than 50 x 10^9/L or an increase in [platelet count] by greater than or equal to 20 x 10^9/L above baseline? Sustained is defined by two separate tests (at least 2 or more weeks apart)?	☐ Yes proceed to question 13	☐ No **STOP** **Coverage not approved**
13. Does the patient have a diagnosis of hypertension?	☐ Yes **proceed to question 14**	☐ No **Sign and date below**
14. Is the patient's hypertension well controlled according to national guidelines (e.g., JNC 8)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[28 November 2018]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: