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| Prior Authorization |
| JOHNS HOPKINS HEALTHCARE (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 Healthcare at 1-410-424-4607 . Please contact Johns Hopkins Healthcare 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. |

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| Drug Name (select from list of drugs shown) Tavalisse (fostamatinib) |
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|-------------------------|----------------------------|----------|
| Quantity | Frequency | Strength |
| Route of Administration | Expected Length of Therapy | |

| | |
|---------------------|-------|
| Patient Information | |
| Patient Name: | _____ |
| Patient ID: | _____ |
| Patient Group No.: | _____ |
| Patient DOB: | _____ |
| Patient Phone: | _____ |

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|-----------------------|-------|
| Prescribing Physician | |
| Physician Name: | _____ |
| Physician Phone: | _____ |
| Physician Fax: | _____ |
| Physician Address: | _____ |
| City, State, Zip: | _____ |

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|-------------------------|------------------------|
| Diagnosis: _____ | ICD Code: _____ |
|-------------------------|------------------------|

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| Comments: _____ |
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| 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)? | <input type="checkbox"/> Y <input type="checkbox"/> 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 $50 \times 10^9/L$ in response to Tavalisse? | <input type="checkbox"/> Y <input type="checkbox"/> N |

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| 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? | <input type="checkbox"/> Y <input type="checkbox"/> 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? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| [No further questions.] | |
| 5. Does the patient have a documented diagnosis of chronic immune idiopathic thrombocytopenia (ITP) with platelet count less than $30 \times 10^9/L$? | <input type="checkbox"/> Y <input type="checkbox"/> 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)? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| NOTE: Submission of medical records is required. | |
| [If no, no further questions.] | |
| 7. Is the patient 18 years of age or older? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| [If no, no further questions.] | |
| 8. Is the requested dose less than or equal to the maximum recommended dose? | <input type="checkbox"/> Y <input type="checkbox"/> 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.

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| Prescriber (Or Authorized) Signature and Date |