OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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. **Incomplete form will delay authorization process.**

Drug Requested: Tavalisse™ (fostamatinib disodium hexahydrate)

DRUG INFORMATON: Complete all information below or authorization process will be delayed.

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: To receive a **THREE (3) month approval** for this drug, **ALL** boxes **must** be checked to qualify to ensure authorization process will **NOT** be delayed.

1) Does member have a diagnosis of chronic immune thrombocytopenia? ❑ Yes ❑ No

AND

2) Is member 18 years or older? ❑ Yes ❑ No

AND

3) Has member failed at least one other therapy for chronic ITP (not achieved a platelet count ≥ 50 x 10^9/L) such as corticosteroids, IV immune globulin, RhO(D) immune globulin, thrombopoietin receptor antagonists, etc.? ❑ Yes ❑ No

AND

4) Member does NOT have concomitant therapy with a strong CYP3A4 inducer. ❑ Yes ❑ No

AND

5) Member has baseline and ongoing routine monitoring which includes: ❑ Yes ❑ No

- CBC (including platelet & neutrophil count), and LFTs monthly
- Blood pressure every 2 weeks until stable dose established, then monthly

For Renewal, complete the following questions to receive a THREE (3) month approval.

1. Member has laboratory values documenting platelet response to therapy (platelet count ≥ 50 x 10^9/L). ❑ Yes ❑ No

(Continued on next page; Signature page MUST be attached to this request form.)

(Signature page MUST be included with request form.)

AND

2. Member has no evidence of severe adverse effects. ❑ Yes ❑ No

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

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 10/27/2018