OPTIMA HEALTH PLAN

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)

DRUG INFORMATION: Complete information below authorization will be delayed**.**

Drug Form/Strength: _____

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

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

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

CLINICAL CRITERIA: Check applicable boxes below to qualify. Boxes **must** be checked to ensure authorization will **NOT** be delayed.

- ❑ Member must have a diagnosis of Chronic Immune Thrombocytopenia (ITP)
- ❑ For initial therapy with Tavalisse®, the following information must be provided:

Baseline Platelet Count (<75 or 30 x10^9/L)		**Baseline ALT (aminotransferase)**	
Date_____	Level: _____	Date: _____	Level: _____

- ❑ For diagnosis of Chronic Immune Thrombocytopenia, patient must have failed **two (2)** of the following: ***(check boxes below that apply)***

❑ corticosteroid	❑ IVIG	❑ splenectomy
❑ Other: _____		

AND

- ❑ Member must have failed **one (1)** of the following therapies: Promacta (eltrombopag) or Nplate (romiplostim)

Medication being provided by (check applicable box below):

- ❑ **Physician's office**

OR

- ❑ **Specialty Pharmacy:**

For Optima Commercial Members:

- ❑ **PropriumRx**

For Optima Family Care Members:

- ❑ **Sentara Norfolk General CM Pharmacy**

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

(Signature page MUST be included with request form)

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 #: _____

*** Approved by Pharmacy and Therapeutics Committee**: 10/18/2018
REVISED/UPDATED: 10/19/2018