Tavalisse (fostamatinib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Relapsed/Refractory Chronic Idiopathic Thrombocytopenia (ITP) ☐ Other diagnosis: _____ICD-10 Code(s): _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Initial Request:

Has patient had ITP for 6 months or greater? ☐ Yes ☐ No ***Please submit chart documentation.***

Is prescriber a hematologist/oncologist? ☐ Yes ☐ No

Does patient have at least 3 platelet counts in the last 3 months that, averaged together, equal less than 30,000? ☐ Yes ☐ No ***Please submit lab report(s).***

If patient has had a platelet count of greater than 35,000 in the last 3 months, was it achieved as a result of rescue therapy? ☐ Yes ☐ No ***Please submit lab report(s) and chart documentation.***

Has patient had an insufficient response to corticosteroids? ☐ Yes ☐ No ***Please submit chart documentation.***

Does patient have an absolute contraindication to corticosteroids? ☐ Yes ☐ No ***Please submit chart documentation.***

Has patient had an insufficient response to immunoglobulins(IVIG)? ☐ Yes ☐ No ***Please submit chart documentation.***

Does patient have an absolute contraindication to immunoglobulins(IVIG)? ☐ Yes ☐ No ***Please submit chart documentation.***

Has patient had an insufficient response to a splenectomy? ☐ Yes ☐ No ***Please submit chart documentation.***

Does patient have an absolute contraindication to a splenectomy? ☐ Yes ☐ No ***Please submit chart documentation.***

Renewal Request:

Is prescriber a hematologist/oncologist? ☐ Yes ☐ No

Does patient have a stable platelet response (at least $50x10^9$/L) ? ☐ Yes ☐ No ***Please submit lab report(s).***

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811