US Family Health Plan
Prior Authorization Request Form for
fostamatinib **(Tavalisse)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial approval is for 4 months, continuation approval is for 12 months

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**

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