

**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: [PRIMETHERAPEUTICS.COM/NOPP](http://PRIMETHERAPEUTICS.COM/NOPP)

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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> 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:**

<input type="checkbox"/> Relapsed/Refractory Chronic Idiopathic Thrombocytopenia (ITP) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
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**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<sup>9</sup>/L) ?  Yes  No *Please submit lab report(s).*



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**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:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Prime Therapeutics Management Prior Authorization Program

Attn: CP – 4201

P.O. Box 64811

St. Paul, MN 55164-0811