## 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  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 OTH	ER 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 ☐ Other diagnosis:ICD			
3. REQUIRED CLINICAL INFORMATIO PRIOR AUTHORIZATION.	N: PLEASE PROVIDE ALL RELEVANT CLINIC	CAL INFORMATION TO SUPPORT A	
Clinical Information: Initial Request: Has patient had ITP for 12 months or	r greater?   Yes   No Please submit	chart documentation.	
Is prescriber a hematologist/oncolog	gist? □ Yes □ No		
Will patient use in combination with and/or Wayrilz(rilzabrutinib)? □ Yes	Promacta(eltrombopag), Nplate(romiple □ No	ostim), Doptelet(avatrombopag),	
Has patient been previously treated Yes □ No Please submit chart doc	and failed to sustain a platelet count of gumentation.	greater than or equal to 50,000/uL? $\Box$	
Has patient had an insufficient respo	onse to corticosteroids? 🗆 Yes 🗆 No	Please submit chart documentation.	
Does patient have an absolute contr	aindication to corticosteroids? $\Box$ Yes $\Box$ N	o Please submit chart documentation.	
Has patient had an insufficient respondence of the documentation.	onse to immunoglobulins(IVIG)? $\Box$ Yes $\Box$	No Please submit chart	
Does patient have an absolute contradocumentation.	aindication to immunoglobulins(IVIG)?	□ Yes □ No Please submit chart	
Has patient had an insufficient respo	onse to rituximab?   Yes   No Please	e submit chart documentation.	
Does patient have an absolute contr	aindication to rituximab?   Yes   No	Please submit chart documentation.	
Has patient had an insufficient respo	onse to eltrombopag?   Yes   No Planta	ease submit chart documentation.	
Does patient have an absolute contradocumentation.	aindication to eltrombopag? □ Yes □ N	o Please submit chart	
Has patient had an insufficient respo	onse to a splenectomy?   Yes   No Pl	ease submit chart documentation.	



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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:	
Does patient have an absolute contraindication.	ion to a splenectomy? □ Yes □ No Please sub	mit chart
Renewal Request:		
Is prescriber a hematologist/oncologist?   \[ \textstyle \textstyl	Yes □ No	
Does patient have a stable platelet response	e (at least 50x10°/L)?   Yes   No Please submit I	ab report(s).
Are there any other comments, diagnoses, sy physician feels is important to this review?	ymptoms, medications tried or failed, and/or any	other information the
<b>Please note:</b> Not all drugs/diagnosis are cover information is received.	red on all plans. This request may be denied unless	s all required
· ·	ded is true and accurate to the best of my knowled designees may perform a routine audit and reque of the information reported on this form.	•
Prescriber Signature or Electronic I.D. Verifica	ation: Date	e:
you are not the intended recipient, you are hereby notif	ing this transmission contain confidential health information t fied that any disclosure, copying, distribution, or action taken ceived this information in error, please notify the sender imm	in reliance on the contents

**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

