Print Reset

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION TAVALISSE™ (fostamatinib disodium hexahydrate)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

TAVALISSE™ – to receive a THREE (3) month approval for this drug, complete the following questions.

1. Does the member have a diagnosis of chronic immune thrombocytopenia? **AND**

   ☐ Yes ☐ No

2. Is the member 18 years or older? **AND**

   ☐ Yes ☐ No

3. Has the member failed at least one other therapy for chronic ITP (not achieved a platelet count ≥ 50 x 10^9/L) such as corticosteroids, IV immune globulin, RhO(D) immune globulin, thrombopoietin receptor antagonists, etc.? **AND**

   ☐ Yes ☐ No

4. The member does NOT have concomitant therapy with a strong CYP3A4 inducer. **AND**

   ☐ Yes ☐ No

5. The member has baseline and ongoing routine monitoring which includes:
   - CBC (including platelet & neutrophil count), and LFTs monthly
   - Blood pressure every 2 weeks until stable dose established, then monthly

   ☐ Yes ☐ No

For renewal, complete the following questions to receive a THREE (3) month approval.

1. The member has laboratory values documenting platelet response to therapy (platelet count ≥ 50 x 10^9/L). **AND**

   ☐ Yes ☐ No

2. The member has no evidence of severe adverse effects.

   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811