BlueCross BlueShield Federal Employee Program

TAVALISSE
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

Tavalisse

(fostamatinib disodium hexahydrate)

**Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?
   - ❑ Chronic Immune Thrombocytopenia (ITP)
   - ❑ Other diagnosis ***(please specify):*** _____

2. Will the patient take Tavalisse with a thrombopoietin receptor agonists? ❑Yes ❑No

3. Has the patient been on Tavalisse continuously for the last **2 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Has the patient had an inadequate response to at least **ONE** of the following therapies: corticosteroids, immunoglobulins, splenectomy, or thrombopoietin receptor agonists? ❑Yes* ❑No

If YES, please specify: _____

b. Does the patient have a baseline platelet count prior to initiation that is less than 50,000 platelets/ mcL? ❑Yes ❑No

c. Does the prescriber agree to monitor liver enzymes (including ALT, AST and bilirubin) and CBC monthly until a stable dose is achieved? ❑Yes ❑No

d. How many tablets are needed for 120 days? _____ tablet(s) per 120 days

❑**YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Has the patient had an improvement in platelet count to 50,000 platelets/ mcL or greater? ❑Yes ❑No

b. Does the prescriber agree to routinely monitor CBC, liver enzymes, and blood pressure throughout therapy? ❑Yes ❑No

c. How many tablets are needed every 90 days? _____ tablet(s) per 90 days

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug prior authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same info contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727** Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the PA request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***