UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2022 P 1253-5
Program	Prior Authorization/Notification
Medication	Tavalisse™ (fostamatinib)
P&T Approval Date	8/2018, 8/2019, 9/2020, 9/2021, 1/2022
Effective Date	4/1/2022; Oxford only: 4/1/2022

1. Background:

Tavalisse (fostamatinib) is a kinase inhibitor indicated for the treatment of thrombocytopenia in adult patients with chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment.

2. Coverage Criteria:

A. Chronic immune thrombocytopenia (ITP)

1. **Initial Authorization**

a. **Tavalisse** will be approved based on **both** of the following criteria

(1) Diagnosis of chronic immune thrombocytopenia (ITP)

-AND-

(2) Patient has had an insufficient response to a previous treatment (e.g., corticosteroids, immunoglobulins, thrombopoietin receptor agonists, splenectomy)

Authorization will be issued for 6 months

2. **Reauthorization**

a. **Tavalisse** will be approved based on the following criterion:

(1) Documentation of positive clinical response to Tavalisse therapy

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Tavalisse [package insert]. South San Francisco, CA: Rigel Pharmaceuticals; November 2020.

Program	Prior Authorization/Notification – Tavalisse (fostamatinib)
Change Control	
8/2018	New program
8/2019	Annual review with no changes to clinical coverage criteria.
9/2020	Annual review. Removed splenectomy from listing of previous treatment requirements.
9/2021	Annual review with no changes to clinical coverage criteria. Reference updated.
1/2022	Revised try/fail criteria to insufficient response.