maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Tavalisse

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1 What is the diagnosis or indication?
[] Chronic Immune Thrombocytopenia (ITP) (If checked, go to 2)

[] B-Cell Lymphomas (If checked, no further questions)

[] Rheumatoid Arthritis (If checked, no further questions)

[] Other (If checked, no further questions)

2 Is this request for initial therapy or for a continuation of therapy?
[] Initial (If checked, go to 3)

If you have any questions, call: 1-888-258-8250

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	[] Continuation (If checked, go to 9)		
3	What is the patient's age? [] Greater than or equal to 18 years of age (If checked, go to 4) [] Less than 18 years of age (If checked, no further questions)		
4	Is the requested medication prescribed by or in consultation with a hematologist? [If no, no further questions.]	Yes	No
5	Has the patient tried at least one other therapy? [Note: Examples of therapies are systemic corticosteroids, intravenous immunoglobulin, anti-D immunoglobulin, Promacta (eltrombopag tablets and oral suspension), Nplate (romiplostim injection for subcutaneous use), Doptelet (avatrombopag tablets), or rituximab.] [If yes, skip to question 7.]	Yes	No
6	Has the patient undergone a splenectomy? [If no, no further questions.]	Yes	No
7	Does the patient have platelet count of less than 30 x 10^9/L (less than 30,000/microliter)? [If yes, no further questions.]	Yes	No
8	Does the patient have a platelet count of less than 50 x 10^9/L (less than 50,000/microliter) and is at an increased risk of bleeding, according to the prescriber? [No further questions.]	Yes	No
9	Has the patient demonstrated a beneficial clinical response (for example, increased platelet counts), according to the prescriber? [If no, no further questions.]	Yes	No
10	Does the patient remain at risk for bleeding complications?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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authorization as per Plan policy and procedures.

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