UnitedHealthcare

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1253-8
Program	Prior Authorization/Notification
Medication	Tavalisse® (fostamatinib disodium hexahydrate)
P&T Approval Date	8/2018, 8/2019, 9/2020, 9/2021, 1/2022, 1/2023, 1/2024, 1/2025
Effective Date	4/1/2025

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]:

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 12 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.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

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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.

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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.
1/2023	Annual review with no changes to clinical coverage criteria. Added state mandate.
1/2024	Annual review with no changes to clinical coverage criteria.
1/2025	Annual review. Updated initial authorization to 12 months.

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