

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1253-9
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, 1/2026
Effective Date	4/1/2026

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.

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.
1/2026	Annual review with no changes to clinical coverage criteria.