Pharmacy Drug Policy & Procedure

Policy Name:	Tavalisse (fostamatinib)	Policy #:	2671P

Purpose of the Policy

The purpose of this policy is to define coverage criteria for Tavalisse (fostamatinib) for the treatment of chronic immune (idiopathic) thrombocytopenia (ITP).

Statement of the Policy

Health Alliance Medical Plans and Health Alliance Northwest will approve the use of Tavalisse (fostamatinib) under the Specialty Pharmacy benefit if the following criteria are met.

Criteria

1. Coverage Criteria

1.1   Diagnosis of chronic immune (idiopathic) thrombocytopenia (ITP)

1.2   Insufficient response or contraindications to the standard of care for ITP (corticosteroids, immunoglobulins, OR splenectomy)

1.3   Prescribed by or in consultation with a hematologist (doctor of blood disorders)

1.4   Age 18 years or older

2. Exclusion Criteria

2.1   Coverage excluded if intent is to solely normalize platelet counts

3. Approval Period

3.1   Initial: 12 months

3.2   Reauthorization: 12 months with documented clinical benefit

CPT Codes

HCPCS Codes

References

1. Tavalisse (fostamatinib) [prescribing information]. South San Francisco, CA: Rigel Pharmaceuticals, Inc; November 2020.
2. Neunert C, Terrell DR, Arnold DM, et al. American Society of Hematology 2019 guidelines for immune thrombocytopenia. Blood Adv. 2019 Dec 10;3(23):3829-3866.
3. Bussel J, Arnold DM, Grossbard E, et al. Fostamatinib for the treatment of adult persistent and chronic immune thrombocytopenia: results of two phase 3, randomized, placebo-controlled trials. Am J Hematol. 2018.

Created Date: 02/13/19
Effective Date: 02/13/19
Posted to Website: 01/01/22
Revision Date: 02/05/25