



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Tavalisse® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Chronic immune (idiopathic) thrombocytopenic purpura (ITP)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Does the patient have relapsed/refractory ITP? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have a baseline platelet count less than 30,000/mcL? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if the patient has had trial and failure, contraindication, or intolerance to the following:					
<input type="checkbox"/> Corticosteroids					
<input type="checkbox"/> Immunoglobulins					
<input type="checkbox"/> Splenectomy					
<input type="checkbox"/> Thrombopoietin receptor agonists (e.g., Nplate, Promacta)					
<input type="checkbox"/> Rituxan (rituximab)					
Is the patient at increased risk for bleeding due to degree of thrombocytopenia and clinical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is Tavalisse prescribed by or in consultation with a hematologist/oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization:					
Is there documentation the patient has had a positive clinical response to Tavalisse therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.