

Clinical Policy: Fostamatinib (Tavalisse)

Reference Number: CP.PHAR.24

Effective Date: 06.05.18

Last Review Date: 02.22

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Fostamatinib (Tavalisse[™]) is an oral spleen tyrosine kinase inhibitor.

FDA Approved Indication(s)

Tavalisse is indicated for the treatment of thrombocytopenia in adult patients with chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Tavalisse is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Immune Thrombocytopenia (must meet all):

1. Diagnosis of chronic ITP;
2. Prescribed by or in consultation with a hematologist;
3. Age \geq 18 years;
4. Current (within 30 days) platelet count $<$ 30,000/ μ L or member has an active bleed;
5. Member meets one of the following (a or b):
 - a. Failure of a systemic corticosteroid;
 - b. Member has intolerance or contraindication to systemic corticosteroids, and failure of an immune globulin, unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
6. Dose does not exceed 300 mg (2 tablets) per day.

**Prior authorization may be required for immune globulins*

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Chronic Immune Thrombocytopenia (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy (e.g., increase in platelet count from baseline, reduction in bleeding events);
3. If request is for a dose increase, new dose does not exceed 300 mg (2 tablets) per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

ITP: immune thrombocytopenia

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Corticosteroids*		
dexamethasone	<u>Oral dosage:</u> Initially, 0.75 to 9 mg/day PO in 2 to 4 divided doses. Adjust according to patient response <u>Intramuscular or intravenous dosage:</u> Initially, 0.5 to 9 mg/day IV or IM in 2 to 4 divided doses. Adjust according to patient response	Highly variable depending on the nature and severity of the disease, route of treatment, and on patient response.
methylprednisolone	<u>Oral dosage:</u>	

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	4 to 48 mg/day PO in 4 divided doses. Adjust according to patient response. <u>Intramuscular or intravenous dosage:</u> 10-40 mg IV every 4-6 hours for up to 72 hours	
prednisone	Initially, 1 mg/kg PO once daily; however, lower doses of 5 mg/day to 10 mg/day PO are preferable for long-term treatment	
Immune globulins		
Immune globulins (e.g., Carimune [®] NF, Flebogamma [®] DIF 10%, Gammagard [®] S/D, Gammaked [™] , Gamunex [®] -C, Gammaplex [®] , Octagam [®] 10%, Privigen [®] , etc.)	Refer to prescribing information	Refer to prescribing information

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

**Examples of corticosteroids/immunosuppressive agents provided are not all inclusive*

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- Definitions of acute vs. chronic ITP:
 - Per an International Working Group consensus panel of ITP experts, ITP is defined as newly diagnosed (diagnosis to 3 months), persistent (3 to 12 months from diagnosis), or chronic (lasting for more than 12 months). Although not formally validated, these definitions are supported and used by the American Society of Hematology (ASH).
- Per the 2019 ASH guidelines, a durable response to treatment was defined by the following:
 - A durable response would be defined as a platelet count $\geq 30,000/\mu\text{L}$ and a greater than 2-fold increase in platelet count from baseline at 6 months.
 - A failure would be defined as a platelet count $< 30,000/\mu\text{L}$ or a less than 2-fold increase in platelet count from baseline.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
ITP	100 mg PO BID; after 4 weeks, increase to 150 mg BID, if needed, to achieve platelet counts of at least $50 \times 10^9/L$	300 mg/day

VI. Product Availability

Tablets: 100 mg, 150 mg

VII. References

1. Tavalisse Prescribing Information. San Francisco, CA: Rigel Pharmaceuticals Inc.; November 2020. Available at: www.tavalisse.com. Accessed November 23, 2021.
2. 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. *American Journal of Hematology*. 2018;93(7):921-930. doi: 10.1002/ajh.25125.
3. Khan AM, Halina M, and Nevarez A. Clinical practice updates in the management of immune thrombocytopenia. *P&T*. 2017;42(12):756-763.
4. Bussel J, Arnold DM, Cooper N, et al. Long-term maintenance of platelet responses in adults with persistent/chronic immune thrombocytopenia treated with fostamatinib: 1-year efficacy and safety results [abstract]. *Blood*. 2017;130:16.
5. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. Available at: <http://www.clinicalpharmacology-ip.com>.
6. Portielje JEA, Westendorp RGJ, Kluin-Nelemans HC, Brand A. Morbidity and mortality in adults with idiopathic thrombocytopenic purpura. *Blood*. 2001;97(9):2549-2554.
7. Neunert C, Terrell D, Arnold D, et al. American Society of Hematology 2019 guidelines for immune thrombocytopenia. *Blood Advances*. 2019;3(23):3829-3866. doi:10.1182/bloodadvances.2019000966.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	06.05.18	08.18
Removed requirement related to splenectomy based on specialist feedback.	08.20.18	11.18
1Q 2019 annual review: added HIM line of business; for platelet count requirement, corrected \leq to $<$ per guidelines; added requirement that initial platelet counts be current (within 30 days); no significant changes; references reviewed and updated.	10.30.18	02.19
1Q 2020 annual review: revised systemic corticosteroid <i>and</i> immune globulin trial to tiered re-direction with immune globulin trial only if corticosteroid cannot be used to align with Nplate criteria, ASH 2011 guideline and specialist feedback; references reviewed and updated.	01.17.20	02.20
1Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	10.12.20	02.21

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: no significant changes; referenced reviewed and updated.	11.23.21	02.22

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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