eltrombopag (PROMACTA)

Diagnoses Considered for Coverage:

- Chronic or persistent immune thrombocytopenia
- Thrombocytopenia associated with HCV INF-based therapy
- Aplastic anemia
- Myelodysplastic syndrome (MDS)-related thrombocytopenia

Coverage Criteria:

For chronic idiopathic thrombocytopenia purpura (ITP):

Initial Authorization
• Platelet count is currently ≤ 30,000/mcl, **and** • Not being used in combination with another thrombopoietin receptor agonist (Doptelet, Nplate), **and** • Inadequate response or intolerable side-effect to ONE of the following therapies: corticosteroids, IVIG, anti-D antibody (e.g. WinRho SDF, Rhophylac), **and** splenectomy OR contraindication to corticosteroids, IVIG, and anti-D, **and** • Dose does not exceed FDA label maximum. ***Coverage Duration:*** 3 months
Reauthorization
• Platelet count is currently greater than baseline and ≤ 400,000 cells/mcl, **and** • Not being used in combination with another thrombopoietin receptor agonist (Doptelet, Nplate), **and** • Dose does not exceed FDA label maximum. ***Coverage Duration:*** Length of benefit

For thrombocytopenia associated with interferon-based therapy for Hepatitis C virus infection:

- Current platelet count is ≤ 75,000 cells/mcl or falls to ≤ 50,000 cells/mcl during HCV therapy, **and**
- Dose does not exceed FDA label maximum.

Coverage Duration: duration of HCV therapy

For severe aplastic anemia:

Initial Authorization
• Patient has not received prior immunosuppressive therapy for aplastic anemia (e.g. ATG, alemtuzumab, cyclosporine), **and** • Being used in combination with antithymocyte globulin (ATG) and cyclosporine, **and** • Dose does not exceed FDA label maximum. ***Coverage Duration:*** 3 months
Reauthorization
• Platelet count is currently ≤ 400,000 cells/mcl, **and** • Dose does not exceed FDA label maximum. ***Coverage Duration:*** 6 months

For myelodysplastic syndrome (MDS)-related thrombocytopenia,

• Patient is not considered high-risk MDS, **and**
• Dose does not exceed FDA label maximum based upon current platelet level, **and**
• One of the following:
  ○ Used as initial treatment in combination with anti-thymocyte globulin (ATG), OR
  ○ Used as initial treatment in combination with ATG and cyclosporine, OR
  ○ Used initial treatment as a single agent, OR
  ○ Inadequate response or intolerable side effect to ONE NCCN supported first-line therapy for low risk MDS. (e.g., hypomethylating agents: decitabine (Dacogen), azacitidine (Vidaza), immunosuppressive therapy (IST): equine antithymocyte globulin (ATG), cyclosporine A, lenalidomide (Revlimid))
 	
Coverage Duration: 6 months
 	
Note to provider: For reauthorization, please provide the current platelet count.

Reauthorization
• Platelet count has increased from baseline and ≤ 400,000 cells/mcl, **and** • Patient disease has not progressed to acute leukemia, **and**

	• Dose does not exceed FDA label maximum based upon current platelet level. ***Coverage Duration***: 6 months
Coverage Duration: see coverage criteria section	

Effective: 11/29/2023