Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Thrombopoietics

A. Prescriptions that Require Prior Authorization

All prescriptions for Thrombopoietics must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Thrombopoietic, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Thrombopoietic by or in consultation with an appropriate specialist (i.e., hematologist/oncologist, gastroenterologist, hepatologist, etc.); **AND**

2. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

3. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. **One** of the following:

a. For a request for treatment of thrombocytopenia prior to a procedure, **both** of the following:

   i. Has a documented pretreatment platelet count < 50 x 10^9/L
   ii. Will begin treatment with the requested Thrombopoietic prior to the scheduled procedure in accordance with FDA-approved package labeling

b. For a request for treatment of other indications, has a documented pretreatment platelet count < 30 x 10^9/L;

AND

5. Has documentation of baseline lab results and monitoring as recommended in the FDA-approved package labeling; **AND**

6. For a request for a non-preferred Thrombopoietic, has documented therapeutic failure, contraindication, or intolerance to the preferred Thrombopoietics approved for the beneficiary's indication. See the Preferred Drug List (PDL) for the list of preferred Thrombopoietics at: https://papdl.com/preferred-drug-list

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR THROMBOPOIETICS: The determination of medical necessity of a request for renewal of a prior authorization for a Thrombopoietic prescribed for an indication other than thrombocytopenia in a beneficiary

scheduled to undergo a procedure that was previously approved will take into account whether the beneficiary:

1. Is prescribed the Thrombopoetic by or in consultation with an appropriate specialist (i.e., hematologist/oncologist, gastroenterologist, hepatologist, etc.); **AND**

2. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. **One** of the following:

a. Has a documented increased platelet count sufficient to avoid bleeding that requires medical attention
b. For treatment of severe aplastic anemia, has documentation of a positive clinical response;

AND

4. Has documentation of repeat lab results and monitoring as recommended in the FDA-approved package labeling; **AND**

5. For renewal requests for Tavalisse (fostamatinib), does not have ≥ grade 3 diarrhea or has a documented plan to manage the diarrhea that is consistent with FDA-approved package labeling

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Thrombopoietic. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

1. Initial and renewal requests for prior authorization of Thrombopoietics will be approved for up to 6 months unless otherwise indicated below.

2. Initial requests for prior authorization of Nplate (romiplostim) for the treatment of ITP will be approved for up to 2 months of therapy.

3. Initial requests for prior authorization of Promacta (eltrombopag) for the treatment

of ITP will be approved for up to 2 months of therapy.

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4. Initial requests for prior authorization of Promacta (eltrombopag) for the treatment

5. of refractory severe aplastic anemia will be approved for up to 5 months of

   therapy.

6. Requests for prior authorization of Promacta (eltrombopag) for the primary treatment of aplastic anemia will be limited to one 6-month course of treatment.

7. Initial requests for prior authorization of Tavalisse (fostamatinib) for the treatment of ITP will be approved for up to 4 months of therapy.

8. Requests for prior authorization of Doptelet (avatrombopag) for the treatment of thrombocytopenia prior to a procedure will be approved for 5 days.

9. Requests for prior authorization of Mulpleta (lusutrombopag) for the treatment of thrombocytopenia prior to a procedure will be approved for 7 days.

   NOTE: Requests for additional courses of therapy of Doptelet (avatrombopag) or Mulpleta (lusutrombopag) for the treatment of thrombocytopenia prior to a procedure will be considered to be an initial request.

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THROMBOPOIETICS PRIOR AUTHORIZATION FORM

☐ **FOR ONCOLOGY USE**			
☐ New request ☐ Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	Office NPI:
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other	

CLINICAL INFORMATION

Drug requested:	Strength:	Weight:
Dose/directions:	Quantity:	Duration:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

INITIAL requests

For a non-preferred Thrombopoietic: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class listed above that are approved or medically accepted for treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.*	☐ Yes ☐ No *Submit documentation.*

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ Has recent results of a CBC with differential
☐ Has recent results of liver function tests
☐ **For treatment of thrombocytopenia prior to a procedure:** Planned procedure date: _____ Planned administration date: _____
  ☐ Has chronic liver disease
  ☐ Has a pretreatment platelet count < 50 x 10^9/L
☐ **For treatment of immune thrombocytopenia:** Duration of thrombocytopenia: _____
  ☐ Has a pretreatment platelet count < 30 x 10^9/L
  ☐ Had an insufficient response to corticosteroids, immunoglobulin, and/or splenectomy
☐ **For treatment of severe aplastic anemia:**
  ☐ Had an insufficient response to immunosuppressive therapy
  ☐ Has a pretreatment platelet count < 30 x 10^9/L
  ☐ Will be used in combination with standard immunosuppressive therapy as first-line treatment
☐ **For treatment of thrombocytopenia with chronic hepatitis C virus infection:**
  ☐ Is or will be receiving interferon therapy

RENEWAL requests

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ Has recent results of a CBC with differential
☐ Has recent results of liver function tests
☐ **For treatment of severe aplastic anemia:**
  ☐ Experienced a positive clinical response since starting the requested medication
☐ **For all treatment of all other conditions:**
  ☐ Platelet count increased to a level sufficient to avoid bleeding that requires medical attention

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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FORM: THROMBOPOIETICS