Highmark Wholecare
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 Thrombopoeitic for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

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

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

4. **One** of the following:

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

      i. Has a 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 treatment of severe aplastic anemia, has **both** of the following:

      i. Marrow cellularity <25% (or 25%-50% with <30% residual haematopoietic cells)

      ii. **Two** of the following:

         1. Neutrophil count <0.5 × 10^9/L,
         2. Platelet count <20 × 10^9/L,
         3. Reticulocyte count <60 × 10^9/L (using an automated reticulocyte count),

   c. For treatment of other indications, has a 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 a history of therapeutic failure of or a contraindication or an intolerance to the preferred Thrombopoietics approved or medically accepted for the beneficiary's indication. See the Preferred Drug List 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 a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

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

3. **One** of the following:

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

   AND

4. Has documentation of repeat lab results and monitoring as recommended in the 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 six months unless otherwise indicated below.

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

3. Initial requests for prior authorization of eltrombopag for the treatment of ITP will be approved for up to two months of therapy.

4. Initial requests for prior authorization of eltrombopag for the treatment of refractory severe aplastic anemia will be approved for up to five months of therapy.

5. Requests for prior authorization of eltrombopag for the primary treatment of aplastic anemia will be limited to one six-month course of treatment.

6. Initial requests for prior authorization of fostamatinib for the treatment of ITP will be approved for up to four months of therapy.

7. Requests for prior authorization of avatrombopag for the treatment of thrombocytopenia prior to a procedure will be approved for five days.

8. Requests for prior authorization of lusutrombopag for the treatment of thrombocytopenia prior to a procedure will be approved for seven days.

NOTE: Requests for additional courses of therapy of avatrombopag or 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 *(form effective 1/6/2025)*

☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

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

Complete all sections that apply to the beneficiary and this request. *Check all that apply and submit documentation for each item.*

INITIAL requests

☐**For ALL requests:**
- ☐Has recent results of a CBC with differential
- ☐Has recent results of liver function tests *(if recommended in the FDA-approved package labeling [e.g., Alvaiz, Promacta, Tavalisse])*

☐**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 previous treatment. Other treatments tried:
  - ☐corticosteroids
  - ☐immune globulin
  - ☐rituximab
  - ☐splenectomy
  - ☐other: _____

☐**For treatment of severe aplastic anemia:**
- ☐Had an insufficient response to immunosuppressive therapy
- ☐Will be used in combination with standard immunosuppressive therapy as first-line treatment
- ☐Has one of the following:
  - ☐marrow cellularity <25%
  - ☐marrow cellularity 25-50% with <30% residual hematopoietic cells
- ☐Has two of the following:
  - ☐neutrophil count <0.5 x 10^9/L
  - ☐platelet count <20 x 10^9/L
  - ☐reticulocyte count <60 x 10^9/L (using an automated reticulocyte count)

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☐ **For treatment of thrombocytopenia with chronic hepatitis C virus infection:**
- ☐ Is or will be receiving interferon therapy
- ☐ Has a pretreatment platelet count <30 x 10^9/L

☐ **For all other indications:**
- ☐ Has a pretreatment platelet count <30 x 10^9/L

☐ **For a NON-PREFERRED Thrombopoietic:**
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Thrombopoietics that are approved or medically accepted for treatment of the beneficiary's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

RENEWAL requests

☐ **For ALL requests:**
- ☐ Has recent results of a CBC with differential
- ☐ Has recent results of liver function tests *(if recommended in the FDA-approved package labeling [e.g., Alvaiz, Promacta, Tavalisse])*

☐ **For treatment of severe aplastic anemia:**
- ☐ Experienced a positive clinical response since starting the requested drug

☐ **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 WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:	**Date**: