Updated: 01/2019
PARP Approved: 3/2019

Prior Authorization Criteria

Thrombopoietin (TPO) Receptor Agonists

All requests for Thrombopoietin (TPO) Receptor Agonists require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

For all requests for Thrombopoietin (TPO) Receptor Agonists all of the following criteria must be met:

- For non-formulary agents, the member has had a trial and failure of a formulary agent or a submitted clinical reason for not having a trial of a formulary agent
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Examples of products and corresponding FDA-approved indications:

Indication	Product
Chronic Immune Thrombocytopenia (ITP)	Nplate, Promacta
Thrombocytopenia in adults with CLD who are scheduled to undergo a procedure	Doptelet, Mulpleta
Thrombocytopenia in adults with hepatitis C to allow initiation and maintenance of interferon-based therapy	Promacta
Aplastic anemia	Promacta

Coverage may be provided with a diagnosis of chronic immune thrombocytopenia (ITP) and the following criteria is met:

- For Nplate, must be at least 1 year old
- For Promacta, must be at least 18 years old
- Must provide documentation of platelet count of $\leq 30{,}000/\mu L$ ($30 \times 10^9/L$)
- Must be prescribed by or in consultation with a hematologist or oncologist
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to both of the following:
  - Four-day trial of corticosteroid therapy
  - IVIG Therapy
- Member has relapsed after splenectomy, or has a contraindication to splenectomy
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
  - Must provide documentation that the member is responding positively to therapy by providing ONE of the following:
    - Increase in platelet count
    - Reduction in bleeding events
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of thrombocytopenia in adult patients with chronic liver disease (CLD) who are scheduled to undergo a procedure and the following criteria is met:

- Must be at least 18 years old

- Must provide documentation of platelet count < 50,000/µL (50 x 10^9/L)
- Must not have a diagnosis of hematologic disorders or have received a platelet transfusion or receipt of blood products containing platelets within 7 days
- Must be used for short-term use prior to a scheduled procedure
- **Initial Duration of Approval:** 1 month

Coverage may be provided with a diagnosis of severe aplastic anemia when the following criteria is met:

- Must be at least 2 years old
- Must provide documentation of platelet count < 30,000/µL (30 x 10^9/L)
- Must be prescribed by or in consultation with a hematologist or oncologist
- Must provide documentation showing one of the following:
    - The member has tried and failed or had an intolerance or contraindication to immunosuppressive therapy (i.e. cyclosporine, Atgam, Thymoglobulin)
    - The member will be using this medication in combination with immunosuppressive therapy (ie. cyclosporine, Atgam, Thymoglobulin)
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
    - Must provide documentation that the member is responding positively to therapy by providing ONE of the following:
        - Increase in platelet count
        - Increase in hemoglobin (Hgb)
        - Increase in absolute neutrophil count (ANC)
- **Reauthorization Duration of Approval:** 12 months

Promacta (eltrombopag) is not covered for the treatment of thrombocytopenia in adults with Hepatitis C to allow the initiation and maintenance of interferon-based therapy. Interferon-based regimens are no longer recommended in the AASLD-IDSA Guidelines for Hepatitis C Treatment.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

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THROMBOPOIETIN (TPO) RECEPTOR AGONISTS PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, provide a JCODE:_____
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

☐ Chronic Immune Thrombocytopenia (ITP), ICD-10: _____
- Ø Does the member have a platelet count ≤ 30,000/µL? ☐ Yes: platelet count: _____ ☐ No
- Ø Which of the following have been tried? ☐ 4-day course of corticosteroid ☐ IVIG ☐ splenectomy
  If none, please explain: _____

☐ Thrombocytopenia with Chronic Liver Disease (CLD), ICD-10: _____
- Ø Is the member scheduled to undergo a procedure? ☐ Yes, date of procedure: _____ ☐ No
- Ø Does the member have a platelet count < 50,000/µL? ☐ Yes: platelet count: _____ ☐ No

☐ Severe aplastic anemia, ICD-10: _____
- Ø Does the member have a platelet count ≤ 30,000/µL? ☐ Yes: platelet count: _____ ☐ No
- Ø Has the member tried immunosuppressive therapy (i.e. cyclosporine, Atgam, Thymoglobulin)? ☐ Yes ☐ No
- Ø Will the requested medication be used in combination with immunosuppressive therapy? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member responded positively to therapy? ☐ Yes ☐ No
If yes, please indicate what improvements have been experienced since starting therapy (check all that apply):
☐ Increase in platelet count ☐ Increase in hemoglobin (Hgb)
☐ Reduction in bleeding events? ☐ Increase in absolute neutrophil count (ANC)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date