Clinical Policy: Thrombopoiesis Stimulating Agents- Doptelet, Nplate, Mulpleta, Promacta, Tavalisse

Reference Number: AZ.CP.PHAR.1019
Effective Date: 07.29.19
Last Review Date: 02.22
Line of Business: Arizona Medicaid (AzCH-CCP and Care1st) Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The following are thrombopoiesis stimulating agents requiring prior authorization: avatrombopag (Doptelet®), eltrombopag olamine (Promacta®), lusutrombopag (Mulpleta®), and romiplostim (Nplate®).

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

AHCCCS preferred drugs in this class include Nplate (romiplostim) and Promacta (eltrombopag) tablets only.

AHCCCS non-preferred drugs in this class include Doptelet (avatrombopag), Mulpleta (lusutrombopag), and Tavalisse (fostamatinib).

FDA approved indication(s)
Nplate is indicated for the treatment of thrombocytopenia in:
- Adult patients with immune thrombocytopenia (ITP) who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy;
- Pediatric patients 1 year of age and older with ITP for at least 6 months who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy.
- Nplate is indicated to increase survival in adults and in pediatric patients (including term neonates) acutely exposed to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome [HS-ARS]).

Promacta is indicated for the treatment of:
- Thrombocytopenia in adult and pediatric patients 1 year and older with chronic immune thrombocytopenia (ITP) who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy. Promacta should be used only in patients with ITP whose degree of thrombocytopenia and clinical condition increase the risk for bleeding.
- Thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy. Promacta should be used only in patients with chronic hepatitis C whose degree of thrombocytopenia prevents the initiation of interferon-based therapy or limits the ability to maintain interferon-based therapy.
- In combination with standard immunosuppressive therapy for the first-line treatment of adults and pediatric patients 2 years and older with severe aplastic anemia.

- Patients with severe aplastic anemia who have had an insufficient response to immunosuppressive therapy.

Doptelet is indicated for the treatment of:
- Thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure.
- Thrombocytopenia in adult patients with chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment.

Mulpleta is indicated for the treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure.

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.

Limitation(s) of use:
- Nplate and Promacta are not indicated for the treatment of patients with myelodysplastic syndromes (MDS).
- Safety and efficacy of Promacta have not been established in combination with direct-acting antiviral agents used without interferon for treatment of chronic hepatitis C infection.
- Nplate should be used only in patients with ITP whose degree of thrombocytopenia and clinical condition increases the risk for bleeding.
- Nplate should not be used in an attempt to normalize platelet counts.

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 Arizona Complete Health-Complete Care Plan and Care1st that Doptelet, Mulpleta, Nplate, Promacta, and Tavalisse are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Persistent/Chronic Immune Thrombocytopenia (must meet all)**:**

1. Diagnosis of persistent or chronic ITP (*see Appendix D*);
2. Request is for one of the following: Doptelet, Nplate, Promacta tablets, or Tavalisse;
3. Prescribed by or in consultation with a hematologist;
4. Member meets one of the following (a or b):
   a. For Nplate or Promacta tablets: age ≥ 1 year;
   b. For Doptelet or Tavalisse: age ≥ 18 years;
5. Current (within 30 days) platelet count is < 30,000/µL or member has an active bleed;
6. Member has 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*);

**Prior authorization may be required for immune globulins*

7. For Doptelet or Tavalisse: Failure of Nplate and Promacta tablets, each used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
8. Doptelet, Promacta, Nplate are not prescribed concurrently with rituximab or another thrombopoietin receptor agonist (e.g., Promacta®, Nplate®, Doptelet®);
9. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months

B. Chronic Hepatitis C-Associated Thrombocytopenia (must meet all):
1. Diagnosis of chronic hepatitis C-associated thrombocytopenia;
2. Request is for Promacta tablets;
3. Prescribed by or in consultation with a hematologist, hepatologist, gastroenterologist or infectious disease specialist;
4. Age ≥ 18 years;
5. Promacta will be used concomitantly with interferon-based therapy;
6. The degree of thrombocytopenia has prevented the initiation of interferon-based therapy or limited the ability to maintain interferon-based therapy;
7. Current (within 30 days) platelet count is < 75,000/µL;
8. Dose does not exceed 100 mg (2 tablets) per day.

Approval duration: 6 months

C. Hematopoietic Syndrome of Acute Radiation Syndrome (must meet all):
1. Diagnosis of HS-ARS with prescriber attestation that there has been suspected or confirmed exposure to radiation levels greater than 2 gray (Gy);
2. Request is for Nplate;
3. Prescribed by or in consultation with a hematologist;
4. Dose does not exceed 10 mcg/kg.

Approval duration: 4 weeks (1 dose only)

D. Severe Aplastic Anemia (must meet all):
1. Diagnosis of severe aplastic anemia;
2. Request is for Promacta tablets;
3. Prescribed by or in consultation with a hematologist;
4. Age ≥ 2 years;
5. Promacta is prescribed for one of the following (a or b):
   a. As first-line therapy in combination with immunosuppressive therapy (e.g., Atgam®, cyclosporine, cyclophosphamide);

b. Refractory or second-line treatment as a single agent following insufficient response to immunosuppressive therapy (e.g., Atgam, cyclosporine, cyclophosphamide);

**Prior authorization may be required for Atgam and cyclosphosphamide*

6. Current (within 30 days) platelet count is < 50,000/µL;
7. Dose does not exceed 150 mg (2 tablets) per day.

Approval duration: 6 months

E. Thrombocytopenia with Chronic Liver Disease (must meet all):

1. Diagnosis of chronic liver disease;
2. Request is for Doptelet or Mulpleta;
3. Prescribed by or in consultation with a hematologist, hepatologist, or gastroenterologist;
4. Age ≥ 18 years;
5. Recent (within the past 14 days) platelet count is < 50 x 10^9/L;
6. Member is scheduled to undergo a medical or dental procedure within the next 30 days;
7. Mulpleta is not prescribed concurrently with another thrombopoietin receptor agonist (e.g., Doptelet®, Nplate®, Promacta®);
8. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 14 days (Mulpleta: no more than 7 total days of treatment; Doptelet: no more than 5 total days of treatment)

F. Recommended NCCN uses (off-label) (must meet all)**:**

1. Request meets one of the following (a or b):
   a. Promacta or Nplate for Myelodysplastic syndromes (MDS);
   b. Nplate for Chemotherapy-induced thrombocytopenia (CIT);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Member has lower-risk MDS (IPSS-R [Very Low, Low, Intermediate]);
4. If Promacta for MDS, one of the following (a or b):
   a. Member has severe or refractory thrombocytopenia following disease progression or no response to hypomethylating agents (e.g., azacitadine, decitabine), immunosuppressive therapy (e.g., Atgam®, cyclosporine), or clinical trial;
   b. Member has thrombocytopenia or neutropenia and one of the following (i, ii, iii, or iv):
      i. Age ≤ 60 years with ≤ 5% marrow blasts;
      ii. Hypocellular marrows;
      iii. Paroxysmal nocturnal hemoglobinuria (PNH) clone positivity;
      iv. *STAT-3* mutant cytotoxic T-cell clones;
5. If Nplate for MDS, member has severe or refractory thrombocytopenia following disease progression or no response to hypomethylating agents (e.g., azacitadine, decitabine), immunosuppressive therapy (e.g., Atgam®, cyclosporine), or clinical trial;

6. For CIT, member has platelets < 100,000/µL for ≥ 3 weeks following the last chemotherapy administration and/or following delays in chemotherapy initiation related to thrombocytopenia;
7. Request meets one of the following (a or b):*
   a. Nplate: Dose does not exceed 10 mcg/kg per week or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*);
   b. Promacta: Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 6 months

G. 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): AZ.CP.PMN.53 for Arizona Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit, member has previously met initial approval criteria, or documentation supports that member is currently receiving Nplate or Promacta for MDS or CIT and has received this medication for at least 30 days;
2. Member is responding positively to therapy (*see Appendix D*);
3. For Persistent/Chronic Immune Thrombocytopenia (must meet all):
   a. Request is for Nplate, Promacta tablets, or Tavalisse;
   b. If request is for Doptelet, history of failure of Nplate and Promacta tablets unless contraindicated or clinically significant adverse effects are experienced;
   c. Current (within the last 90 days) platelet count is < 400,000/µL;
   d. Doptelet, Promacta, Nplate is not prescribed concurrently with rituximab or another thrombopoietin receptor agonist (e.g., Promacta®, Nplate®, Doptelet®);
4. For Chronic Hepatitis C-associated Thrombocytopenia (must meet all):
   a. Request is for Promacta tablets;
   b. Current (within the last 90 days) platelet count is < 400,000/µL;
   c. Member continues to receive interferon-based therapy;
5. Hematopoietic Syndrome of Acute Radiation Syndrome
   a. Re-authorization is not permitted. Members must meet the initial approval criteria.
6. For Severe Aplastic Anemia (must meet all):
   a. Request is for Promacta tablets;
   b. Current (within the last 90 days) platelet count is < 400,000/µL;
7. For Thrombocytopenia with Chronic Liver Disease (must meet all):
   a. Request is for Doptelet or Mulpleta;

b. Re-authorization is not permitted. Members must meet the initial approval criteria;

8. For recommended NCCN uses (off-label) (must meet all):
   a. Request is for Nplate or Promacta;
   b. If request is for a dose increase, request meets one of the following (i or ii):*
      i. Nplate: New dose does not exceed 10 mcg/kg per week or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*);
      ii. Promacta: New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN*
9. If request is for a dose increase, new dose does not exceed maximum dose indicated in Section V.

Approval duration:
Thrombocytopenia with Chronic Liver Disease – Not applicable;
Hematopoietic Syndrome of Acute Radiation Syndrome– Not applicable;
Hepatitis C-associated thrombocytopenia – 6 months;
All other indications – 12 months

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 – AZ.CP.PMN.53 for Arizona Medicaid

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
ITP: immune thrombocytopenia
IPSS: International Prognostic Scoring System
IPSS-R: Revised International Prognostic Scoring System
ITP: chronic immune thrombocytopenia
HS-ARS: hematopoietic syndrome of acute radiation syndrome
MDS: myelodysplastic syndromes
WPSS: WHO Classification-based Prognostic Scoring System

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*		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
dexamethasone	**ITP** Oral dosage: *Adults*: Initially, 0.75 to 9 mg/day PO, given in 2 to 4 divided doses. Adjust according to patient response. *Children and adolescents*: 0.02 to 0.3 mg/kg/day PO or 0.6 to 9 mg/m^2/day PO, given in 3 to 4 divided doses Intramuscular or intravenous dosage: *Adults*: Initially, 0.5 to 9 mg/day IV or IM, given in 2 to 4 divided doses. Adjust according to patient response. *Children*: 0.02 to 0.3 mg/kg/day or 0.6 to 9 mg/m^2/day IV or IM given in 3-4 divided doses. Adjust according to patient response.	Dosage must be individualized and is highly variable depending on the nature and severity of the disease, route of treatment, and on patient response.
methylprednisolone	**ITP** Oral dosage: *Adults*: 4 to 48 mg/day PO in 4 divided doses. Adjust according to patient response. *Children*: 0.5 to 1.7 mg/kg/day PO in divided doses every 6 to 12 hours Intravenous dosage: *Adults*: 10 to 40 mg IV every 4 to 6 hours for up to 72 hours *Children*: 0.11 to 1.6 mg/kg/day IV in 3 or 4 divided doses.	Dosage must be individualized and is highly variable depending on the nature and severity of the disease, route of treatment, and on patient response.
prednisone	**ITP** *Adults*: 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.	Dosage must be individualized and is highly variable depending on the nature and severity of the disease, route of treatment, and on patient response.
Immune globulins		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
immune globulins (e.g., Carimune® NF, Flebogamma® DIF 10%, Gammagard® S/D, Gammaked™, Gamunex®-C, Gammaplex®, Octagam® 10%, Privigen®)	**ITP** Refer to prescribing information	Refer to prescribing information
Immunosuppressive agents*		
Atgam® (antithymocyte globulin)	**Aplastic anemia** 10 to 20 mg/kg/day IV infusion for 8 to 14 days, continuing with every-other-day dosing up to a total of 21 doses, if needed Off-label dosing: 40 mg/kg IV daily for four consecutive days in combination with cyclosporine	Varies
cyclosporine† (Sandimmune®)	**Aplastic anemia** 12 mg/kg PO daily	Varies
cyclophosphamide†	**Aplastic anemia** 45 to 50 mg/kg IV divided over 4 days	Varies

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*
†Off-label indication

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): In patients with chronic hepatitis C, Promacta in combination with interferon and ribavirin may increase the risk of hepatic decompensation. Promacta may increase the risk of severe and potentially life threatening hepatotoxicity. Monitor hepatic function and discontinue dosing as recommended.

Appendix D: General Information

- Definition of persistent vs chronic ITP per the 2019 American Society of Hematology Guideline
  - Persistent ITP: ITP duration of 3-12 months
  - Chronic ITP: ITP duration of > 12 months

- Examples of positive response to therapy may include:
  - For ITP or hepatitis C-associated thrombocytopenia:
    - Increase in platelet count from baseline levels;
    - Platelet count ≥ 50,000/µL;
    - Reduction in clinically important bleeding events;
  - For aplastic anemia: any of the following hematologic responses:
    - Platelet count ≥ 50,000/µL;
    - Platelet count increases to 20,000/µL above baseline or stable platelet counts with transfusion independence for a minimum of 8 weeks;
    - Hemoglobin increase > 1.5 g/dL, or a reduction of ≥ 4 units of red blood cell (RBC) transfusions for 8 consecutive weeks;
    - Absolute neutrophil count (ANC) increase of 100% or an ANC increase greater than 500/µL.
- Examples of chronic liver disease include: alcoholic liver disease, chronic viral hepatitis (e.g., hepatitis B and C), and nonalcoholic steatohepatitis.
- MDS prognostic scoring system online calculator for IPSS-R: https://qxmd.com/calculate/calculator_109/mds-revised-international-prognostic-scoring-system-ipss-r
- Definitions of acute v. 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, response to treatment was defined by the following:
  - A response is defined as a platelet count ≥ 30,000/µL and a greater than 2-fold increase in platelet count from baseline measured on 2 occasions > 7 days apart and the absence of bleeding.

  A failure would be defined as a platelet count < 30,000/µL or a less than 2-fold increase in platelet count from baseline or the presence of bleeding. Platelet count must be measured on 2 occasions more than a day apart.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
avatrombopag (Doptelet)	Thrombocytopenia with chronic liver disease	Platelet count < 40 x 10^9/L: 60 mg PO QD for a total of 5 days Platelet count of 40 to < 50 x 10^9/L: 40 mg PO QD for a total of 5 days	See regimen

Drug Name	Indication	Dosing Regimen	Maximum Dose
	Chronic ITP	Initiate at 20 mg PO QD and titrate to maintain platelet count ≥ 50 x10^9/L	40 mg/day
eltrombopag (Promacta)	Persistent or chronic ITP	Adults and pediatrics age ≥ 6 years: 50 mg PO QD Pediatrics age 1 to 5 years: 25 mg PO QD Dose reductions are needed for patients with hepatic impairment and some patients of East Asian ancestry. Adjust to maintain platelet count greater than or equal to 50,000/µL.	75 mg/day
	Chronic hepatitis C-associated thrombocytopenia	25 mg PO QD Adjust to achieve target platelet count required to initiate antiviral therapy.	100 mg/day
	Severe aplastic anemia	After an insufficient response to immunosuppressive therapy: 50 mg PO QD Reduce initial dose in patients with hepatic impairment or patients of East Asian ancestry. Adjust to maintain platelet count greater than 50,000/µL. For first-line treatment in combination with immunosuppressive therapy: Patients 12 years and older: 150 mg PO QD	150 mg/day

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Patients 6 to 11 years: 75 mg PO QD Patients 2 to 5 years: 2.5 mg/kg PO QD Reduce initial dose in patients with hepatic impairment or patients of East Asian ancestry. Adjust to maintain platelet count greater than 50,000/µL. Total duration of treatment is 6 months.	
fostamatinib (Tavalisse)	ITP	100 mg PO BID; after 4 weeks, increase to 150 mg BID, if needed, to achieve platelet counts of at least 50 x 10^9/L	300 mg/day
lusutrombopag (Mulpleta)	Thrombocytopenia	3 mg PO QD for a total of 7 days	3 mg/day
romiplostim (Nplate)	ITP	The initial dose is 1 mcg/kg SC based on actual body weight. Adjust weekly dose by increments of 1 mcg/kg to achieve and maintain a platelet count ≥ 50,000/µL as necessary to reduce the risk for bleeding. Do not dose if platelet count is > 400,000/µL.	10 mcg/kg/week
	HS-ARS	10 mcg/kg administered once as a SC injection. Administer the dose as soon as possible after suspected or confirmed exposure t myelosuppressive doses of radiation.	10 mcg/kg

VI. Product Availability

Drug Name	Availability
avatrombopag (Doptelet)	Tablet: 20 mg
eltrombopag (Promacta)	Tablets: 12.5 mg, 25 mg, 50 mg, 75 mg Oral suspension: 12.5 mg, 25 mg
fostamatinib (Tavalisse)	Tablet: 100 mg, 150 mg
lusutrombopag (Mulpleta)	Tablet: 3 mg
romiplostim (Nplate)	Lyophilized powder in single-dose vials for injection: 125 mcg, 250 mcg, 500 mcg

VII. References

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Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2796	Injection, romiplostim, 10 mcg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	07.29.19	07.19

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added criterion to continued therapy for history of failure of Nplate and Promacta tablets for Doptelet only for CIT indication, since grandparenting only applies to Tavalisse; Added new CIT indication for Doptelet.	10.7.19	10.19
1Q 2020 annual review: updated failure of corticosteroids and immune globulins to be at up to maximally indicated dose for dx of Chronic Immune Thrombocytopenia; **For Nplate and Promacta**, revised criteria to allow use in non-chronic ITP per revised prescribing information; removed MDS from excluded diagnoses and added criteria set as NCCN supported category 2A recommendation for use; references reviewed and updated. Renumbered criteria from AZ.CP.PHAR.05 to AZ.CP.PHAR.1019.	01.13.20	01.20
For chronic immune thrombocytopenia: added requirement that Doptelet, Promacta, Nplate is not prescribed concurrently with rituximab or other thrombopoietin receptor agonists for ITP; revised systemic corticosteroid and immune globulin trial to tiered re-direction with immune globulin trial only if corticosteroid cannot be used per ASH 2011 guideline and specialist feedback.	07.13.20	07.20
Minor formatting changes; Changed "Diagnosis of chronic ITP; or for Nplate diagnosis of ITP" to " Diagnosis of ITP" for simplification; Changed Approval duration for Thrombocytopenia with chronic liver disease from 6 months to 14 days (Mulpleta: no more than 7 total days of treatment; Doptelet: no more than 5 total days of treatment); Clarified drug specific maximum dosing for myelodysplastic syndromes; For Section II. Continued Therapy, added "documentation supports that member is currently receiving Nplate or Promacta for MDS and has received this medication for at least 30 days" as MDS is an oncology indication, added "Doptelet, Promacta, Nplate is not prescribed concurrently with rituximab or another thrombopoietin receptor agonist (e.g., Promacta®, Nplate®, Doptelet®)"; Updated References.	10.23.20	10.20

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2021 annual review: for aplastic anemia clarified use either as first-line combination therapy or second-line as monotherapy, removed upper age limit for combination therapy per clinical trial baseline characteristics of study population; for myelodysplastic syndromes, clarified dose limits for Nplate that dose does not exceed 10 mcg/kg per week or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use; for thrombocytopenia with chronic liver disease, added requirement that Mulpleta is not prescribed concurrently with other thrombopoietin receptor agonists; references reviewed and updated.	01.30.21	02.21
1Q 2021 for Promacta- references reviewed and updated. For Nplate- RT4 added criteria for recently added FDA approved indication, HS-ARS; references reviewed and updated.	3.22.21	05.21
Added Care1st logo. Added verbiage to specify that criteria also applies to Care1st.	5.10.21	04.21
1Q 2022 annual review: clarified definition of persistent vs chronic ITP in Appendix D per 2019 ASH guideline; for MDS removed IPSS and WPSS risk categorizations as IPSS-R is preferred per NCCN; included criteria for specific circumstances for MDS where disease progression on other agents is not necessary per NCCN; added CIT off-label indication per NCCN; For Doptelet: removed redirection to Mulpleta; Updated Tavalisse as an oral spleen tyrosine kinase inhibitor in the Description section. Updated criteria in response to FDA label revision to include persistent or chronic ITP; references reviewed and updated.	1.27.22	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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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.