



MEDICAL POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
01/18/2013	02/18/2016	09/08/2015
Policy Name	Policy Number	
Immune (Idiopathic) Thrombocytopenia Purpura (ITP)	SRx-0018	

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

For Medicare plans please reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD):

A. SUBJECT

Immune (Idiopathic) Thrombocytopenia Purpura (ITP)

- Eltrombopag (Promacta)
- Romiplostim (NPlate)

B. BACKGROUND

The CareSource medication policies are therapy class policies that are used as a guide when determining health care coverage for our members with benefit plans covering prescription drugs. Medication policies are written on selected prescription drugs requiring prior authorization or Step-Therapy. The medication policy is used as a tool to be interpreted in conjunction with the member's specific benefit plan.

The intent of thrombopoiesis stimulating agents such as Promacta, NPlate program is to encourage appropriate selection of therapy for patients according to product labeling and/or clinical guidelines and/or clinical studies, and also to encourage use of preferred agents.

C. DEFINITIONS

N/A

D. POLICY

CareSource will approved the use of Eltrombopag (Promacta) and romiplostim (NPlate), and consider their use as medically necessary when the following criteria have been met for:

- Thrombocytopenia due to chronic immune (idiopathic) thrombocytopenic purpura (ITP)
- Thrombocytopenia associated with Hepatitis C infection to allow the initiation and maintenance of interferon-based therapy; (Promacta ONLY)
- Severe aplastic anemia in patients that have had insufficient response to immunosuppressive therapy (Promacta ONLY)



- I. **Romiplostim (NPlate)** is indicated for the treatment of thrombocytopenia in adults with chronic immune (idiopathic) thrombocytopenic purpura (ITP) whose degree of thrombocytopenia and clinical condition increases the risk for bleeding, and have not responded to treatment with corticosteroids, immunoglobulins or splenectomy.
- A. **Prior Authorization Criteria ITP:**
1. Documented diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP) made by a hematologist
 2. Platelet count less than 20,000/mm³ or platelet count less than 30,000/mm³ accompanied by symptoms of bleeding
 3. Patient has documented insufficient response to corticosteroids, immunoglobulins or splenectomy or has **1 (one)** of the following exceptions:
 - 3.1 Unable to tolerate or has a medical contraindication to corticosteroids or immunoglobulins
 - 3.2 Have a contraindication to splenectomy
 4. Patient is 18 years or older
- II. **Eltombopag (Promacta)** is indicated for the treatment when criteria are met for **1 (one)** of the following:
- A. **Thrombocytopenia in patients with Chronic Immune (Idiopathic) Thrombocytopenic Purpura (ITP)**
1. Documented diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP) made by a hematologist
 2. Patient is greater than **1 (one)** year of age.
 3. Platelet count less than 20,000/mm³ or Platelet count less than 30,000/mm³ accompanied by symptoms of bleeding
 4. Patient has documented insufficient response to corticosteroids, immunoglobulins or splenectomy or **1 (one)** of the following exceptions:
 - 3.1 Unable to tolerate or has a medical contraindication to corticosteroids or immunoglobulins
 - 3.2 Have a contraindication to splenectomy
- B. **Thrombocytopenia in Patients with Chronic Hepatitis C**
1. Documented diagnosis of Thrombocytopenic made by, or in consultation with a hematologist
 2. Documented diagnosis of chronic hepatitis C
 3. Patient is 18 years of age or older
 4. Patient unable to initiate or maintain interferon (IFN) therapy due to platelet count less than 75,000/mm³, and a Child-Pugh level A (score 5-6)
- C. **Severe Refractory Aplastic Anemia**
1. Documented diagnosis of Severe Refractory Aplastic Anemia made by, or in consultation with a hematologist
 2. Documentation of a baseline severe cytopenia (severe aplastic anemia), with at least **2 (two)** of the following three criteria:
 - 2.1 Reticulocyte count less than 20,000/ m³
 - 2.2 Platelet count less than 20,000/ m³
 - 2.3 Absolute neutrophil count (ANC) less than 500/m³
 3. Baseline platelet count of less than 30,000/m³
 4. Patient is 18 years of age or older
 5. Documented failure of **4 (four) months or more** of immunosuppressive therapy

NOTE: These agents are not indicated and should not be used in an attempt to normalize platelet counts.



NOTE: Aspirin is contraindicated with member diagnosed with ITP. If member has chronic hepatitis C and takes eltrombopag with medications for hepatitis C, called interferon (Peginterferon, Pegintron, others) and ribavirin, there is an increased risk they will develop serious liver damage.

NOTE: Pregnant women require special consideration for delivery:

- a. If the platelet count is greater than $50 \times 10^9/L$ ($>50 \times 10^3/\mu L$), the risk of serious hemorrhage is low, but beginning oral prednisone a week before delivery is a reasonable precaution.
- b. If the platelet count is less than $50 \times 10^9/L$ ($50 \times 10^3/\mu L$) before delivery, treatment with oral prednisone and IVIG is recommended. The safety of thrombopoietin mimetics in pregnancy and breastfeeding has not been established.
- c. The standard dose of IV RhIG for ITP contains approximately 10-fold the concentration of anti-D that is in the standard antepartum dose of intramuscular RhIG for Rh immunoprophylaxis. Although the effects on an Rh(D)-positive fetus are unknown, avoiding the use of IV RhIG in this situation until safety data are available is advisable.
- d. Rarely, splenectomy may be required to manage acute hemorrhage

NOTE: Documented diagnosis must be confirmed by contemporaneous portions of the individual's medical record which will confirm the presence of disease and will need to be supplied with prior authorization request. These medical records may include, but not limited to test reports, chart notes from provider's office or hospital admission notes. **ALL** other uses of Promacta, NPlate are considered experimental/investigational and therefore, will follow CareSource's Off-Label policy.

Refer to the product package insert for dosing, administration and safety guidelines.

For Medicare Plan members, refer to the CareSource policy and Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD).

If there is no NCD or LCD present, reference the CareSource Policy for coverage.

NOTE: Eltrombopag (Promacta) is available only through a restricted distribution program called PROMACTACARES. Under the PROMACTACARES Program, only prescribers, pharmacies, and patients registered with the program are able to prescribe, dispense, and receive eltrombopag (Promacta). To enroll in the PROMACTACARES Program call: 1-877-9-PROMACTA.

NOTE: Romiplostim (Nplate) is available only through a restricted distribution program called Nplate NEXUS (Network of Experts Understanding and Supporting Nplate and Patients) Program. Under the Nplate NEXUS Program, only prescribers and patients registered with the program are able to prescribe, administer, and receive romiplostim (Nplate).

CONDITIONS OF COVERAGE

HCPCS J8999 Promacta
 J2796 NPlate

CPT

Step Therapy

Under some plans, including plans that use an open or closed formulary, some of the medications in this policy may be subject to step-therapy. Refer to the CareSource formulary tool or PDL for further guidance.



PLACE OF SERVICE

Promacta: Preferred place of service: *Home*

Nplate: Preferred place of service: *Office, Outpatient*

NOTE: CareSource supports administering injectable medications in various settings, as long as those services are furnished in the most appropriate and cost-effective setting that are supportive of the patient's medical condition and unique needs and condition. The decision on the most appropriate setting for administration is based on the member's current medical condition and any required monitoring or additional services that may coincide with the delivery of the specific medication.

AUTHORIZATION PERIOD

Coverage may be approved for up to 12 weeks and should be discontinued if the platelet count does not increase to a level sufficient to avoid clinically important bleeding after weeks of therapy at the maximum dose.

Reauthorization requirements are as follows:

For ITP Continued authorization or re-authorization (after the initial 12 week period) shall be reviewed at least every **3 (three)** months to confirm that current medical necessity criteria are met and that the medication is effective:

1. The patient's recent (within the last 30 days) platelet count is either: Equal to or greater than $30,000/\text{mm}^3$ but not more than $150,000/\text{mm}^3$ OR Less than $30,000/\text{mm}^3$ but platelet counts have increased from baseline accompanied with a resolution of previous bleeding

For Thrombocytopenia in Patients with Chronic Hepatitis C continued authorization or re-authorization (after the initial 4 week period) shall be reviewed at least every **3 (three)** months to confirm that current medical necessity criteria are met and that the medication is effective:

1. The patient remains on interferon/ribavirin therapy and platelet count is less than $400,000/\text{mm}^3$

For Severe Aplastic anemia continued authorization or re-authorization (after the initial **4 (four)** week period) shall be reviewed at least every **3 (three)** months to confirm that current medical necessity criteria are met and that the medication is effective: The patient has a documented hematologic response, based on blood counts AND/OR a reduced need for blood products and **1 (one)** of the following:

1. Platelet count equal to or greater than $30,000/\text{mm}^3$ but not more than $150,000/\text{mm}^3$
 2. Platelet count less than $30,000/\text{mm}^3$ but $20,000/\text{mm}^3$ more than baseline.
 3. Reduction in RBC transfusions (of at least 4 units) or hemoglobin increase of at least 1.5 g/dL from baseline.
 4. Absolute neutrophil count (ANC) increase of 100% from baseline or an ANC increase greater than $500/\text{mm}^3$.
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Appendix A – Child-Pugh Classification of Severity of Liver Disease

Child-Pugh Classification	Points		
A: well-compensated disease	5 to 6		
B: significant functional compromise	7 to 9		
C: decompensated disease	10 to 15		
	Points Assigned		
Parameter	1	2	3
Ascites	Absent	Slight	Moderate
Bilirubin (mg/dl)	<2	2 to 3	>3
Albumin (g/dl)	>3.5	2.8 to 3.5	<2.8
Protrombin Time			
Seconds over control	1 to 3	4 to 6	>6
INR	<1.7	1.8 to 2.3	>2.3
Encephalopathy	None	Grade 1 to 2	Grade 3 to 4

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued: 01/18/2013
Date Reviewed: 01/18/2013
01/18/2014 – Changed platelet criteria, added Hep C indications, added values for reauth period, change auth period
Date Revised: 02/18/2015 – Revision to current policy to include aspirin contraindication, pregnancy special considerations, and updated references.
9/08/2015 Added age change for ITP and Promacta, added indication for severe aplastic anemia

G. REFERENCES

1. GlaxoSmithKline. Promacta (eltrombopag) prescribing information. Research Triangle Park, NC: GlaxoSmithKline. June 2015.
2. Amgen, Inc. Nplate (romiplostim) Prescribing Information. Thousand Oaks, CA: Amgen, Inc. 02/2014.
3. Facts and Comparison. <http://online.factsandcomparisons.com/index.aspx>
4. Bussel JB, Cheng G, Saleh MN, et al. Safety and Efficacy of Long-Term treatment with Oral Eltrombopag for Chronic Idiopathic Thrombocytopenic Purpura. 50th ASH Annual Meeting and Exposition, Dec. 6-9. San Francisco, CA; 2008.
5. Schwartz RS. Immune thrombocytopenic purpura--from agony to agonist. *N Engl J Med*. Nov 29 2007;357(22):2299-2301.
6. Toltl LJ, Arnold DM. Pathophysiology and management of chronic immune thrombocytopenia: focusing on what matters. *Br J Haematol*. 2011;152:52.
7. George JN. Chronic refractory immune (idiopathic) thrombocytopenic purpura in adults. In: Basow DS, ed. *UpToDate*. Waltham, MA: UpToDate; 2011.
8. Bussel JB, Kuter DJ, George JN, et al. AMG 531, a thrombopoiesis-stimulating protein, for chronic ITP. *N Engl J Med*. 2006; 355:1672.
9. Kuter DJ, Bussel JB, Lyons RM, et al. Efficacy of romiplostim in patients with chronic immune thrombocytopenic purpura: a double-blind randomized controlled trial. *Lancet*. 2008; 371:395.
10. Bussel JB, Cheng G, Saleh MN, et al. Eltrombopag for the treatment of chronic idiopathic



- thrombocytopenic purpura. *N Engl J Med*. 2007; 357:2237.
11. Bussel JB, Provan D, Shamsi T, et al. Effect of eltrombopag on platelet counts and bleeding during treatment of chronic idiopathic thrombocytopenic purpura: a randomized, double-blind, placebo-controlled trial. *Lancet*. 2009; 373:641.
 12. [Fazal A. Danish](#), [Salman S. Koul](#), [Fazal R. Subhani](#), [Ahmed E. Rabbani](#), and [Saeeda Yasmin](#). Considerations in Management of Hepatitis C Virus related Thrombocytopenia with Eltrombopag, US National Library of Medicine National Institutes of Health, Saudi Gastroenterol.v.16(1); Jan-Mar 2010.
 13. Kessler, C., Sandler, S., Kosty, M., Talavera, F., Sacher, R., McKenna, R., & Besa, E. (2014, April 21). Immune Thrombocytopenic Purpura Treatment & Management. Retrieved February 16, 2015, from <http://emedicine.medscape.com/article/202158-treatment>
 14. Eltrombopag. (2015, January 1). Retrieved January 1, 2015, from <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a609011.html>

The medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.

Independent medical review – 11/19/2012
