Clinical Policy: Eltrombopag (Promacta)

Reference Number: CP.PHAR.180
Effective Date: 03.01.16
Last Review Date: 02.18
Line of Business: Commercial, Health Insurance Marketplace, Medicaid Revision Log

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

Description
Eltrombopag (Promacta®) is a thrombopoietin receptor agonist.

FDA Approved Indication(s)
Promacta is indicated:

- For the treatment of thrombocytopenia in adult and pediatric patients 1 year and older with chronic immune (idiopathic) thrombocytopenia (ITP) who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy
- For the treatment of thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy
- For the treatment of patients with severe aplastic anemia who have had an insufficient response to immunosuppressive therapy

Limitation(s) of use:

- Promacta should be used only in patients with ITP whose degree of thrombocytopenia and clinical condition increase the risk for bleeding.
- 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. Safety and efficacy have not been established in combination with direct-acting antiviral agents used without interferon for treatment of chronic hepatitis C infection.

Policy/Criteria
Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Promacta is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Thrombocytopenia (must meet all)**:**

1. Diagnosis of one of the following (a, b, or c):
   a. Chronic ITP, and (i through vi):
      i. Prescribed by or in consultation with a hematologist;
      ii. Age ≥ 1 year;
      iii. Member has had an insufficient response to the following first line agents: corticosteroids and immunoglobulins;

iv. Member has relapsed after splenectomy, or has a contraindication to splenectomy;
v. Platelet count is < 30 x 10^9/L, or member has an active bleed;
vi. Dose does not exceed 75 mg per day;

b. Chronic hepatitis C-associated thrombocytopenia, and (i through vi):
i. Prescribed by or in consultation with a hematologist, hepatologist, gastroenterologist or infectious disease specialist;
ii. Age ≥ 18 years;
iii. Promacta will be used concomitantly with interferon-based therapy;
iv. The degree of thrombocytopenia has prevented the initiation of interferon-based therapy or limited the ability to maintain interferon-based therapy;
v. Platelet count is < 75 x 10^9/L;
vi. Dose does not exceed 100 mg per day;

c. Severe aplastic anemia, and (i through v):
i. Prescribed by or in consultation with a hematologist;
ii. Age ≥ 18 years;
iii. Member has had an insufficient response to immunosuppressive therapy (e.g., antithymocyte globulin, cyclosporine A, cyclophosphamide);
iv. Platelet count is < 50 x 10^9/L;
v. Dose does not exceed 150 mg per day.

Approval duration: 6 months

B. 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): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Thrombocytopenia (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy (e.g.; for ITP or hepatitis C-associated thrombocytopenia: increase in platelet count from baseline levels; for aplastic anemia any of the following hematologic responses: 1) platelet count increases to 20 x 109/L above baseline, or stable platelet counts with transfusion independence for a minimum of 8 weeks; 2) hemoglobin increase by greater than 1.5 g/dL, or a reduction in greater than or equal to 4 units of red blood cell (RBC) transfusions for 8 consecutive weeks; 3) absolute neutrophil count (ANC) increase of 100% or an ANC increase greater than 0.5 x 10^9/L);
3. Current (dated within that last 90 days) platelet count is < 400 x 10^9/L;
4. If diagnosis of chronic hepatitis C-associated thrombocytopenia, continuation of antiviral therapy;
5. If request is for a dose increase, new dose does not exceed the following:
a. Chronic ITP: 75 mg per day;
b. Chronic hepatitis C-associated thrombocytopenia: 100 mg per day;

c. Severe aplastic anemia: 150 mg per day.

Approval duration: 12 months, or 6 months for hepatitis C-associated thrombocytopenia

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. 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): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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 – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
ANC: absolute neutrophil count
FDA: Food and Drug Administration
ITP: immune (idiopathic) thrombocytopenia

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*		
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*: 0.024 to 0.34 mg/kg/day PO or 0.66 to 10 mg/m^2/day PO, given in 2 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:* 0.06 to 0.3 mg/kg/day or 1.2 to	Dosage must be individualized and is highly variable depending on the nature and severity of the disease, route of treatment, and on patient response

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	10 mg/m^2/day IV or IM in divided doses every 6 to 12 hours. Adjust according to 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	
Immunoglobulins		
Carimune® NF, Flebogamma® DIF 10%, Gammagard® S/D, Gammaked™, Gamunex®-C, Gammaplex®, Octagam® 10%, Privigen®	Refer to prescribing information	Refer to prescribing information
Immunosuppressive agents*		
Atgam (antithymocyte globulin)	Aplastic anemia 10-20 mg/kg/day IV infusion for 8-14 days, continuing with every-other-day dosing up to a total of 21 doses, if needed Off-label dosing: 40 mg/kg 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

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Chronic ITP	Adults and pediatrics ≥ 6 years: 50 mg PO once daily Pediatrics 1 to 5 years: 25 mg PO once daily	75 mg per day

Indication	Dosing Regimen	Maximum Dose
	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 x 10^9/L.	
Chronic hepatitis C-associated thrombocytopenia	25 mg PO once daily Adjust to achieve target platelet count required to initiate antiviral therapy.	100 mg per day
Severe aplastic anemia	50 mg PO once daily Reduce initial dose in patients with hepatic impairment or patients of East Asian ancestry. Adjust to maintain platelet count greater than 50 x 10^9/L.	150 mg per day

VI. Product Availability

Tablets: 12.5 mg, 25 mg, 50 mg, and 75 mg

VII. References

1. Promacta Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; October 2017. Available at https://www.us.promacta.com/. Accessed November 14, 2017.
2. Neunert C, Lim W, Crowther M, et al. The American Society of Hematology 2011 evidence-based practice guideline for immune thrombocytopenia. Blood. 2011; 117(16): 4190-4207.
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2017. Available at: http://www.clinicalpharmacology-ip.com/.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy converted to new template and split from CP.PHAR.53. TPO RAs. Criteria: age added per PI; documentation requests removed; changed all approval periods to 3 and 6 months; changed platelet criteria from <30,000 platelets at time of diagnosis to current platelet count <50,000 for ITP and aplastic anemia; for Hep C changed platelet criteria from <75,000 at time of diagnosis to current platelet count <100,000.	03.16	03.16
Removed age restriction. Added requirement for specialist to be involved in care. For Chronic ITP, changed platelet criteria to <30, and modified trial to require the use of the 2 first line agents: corticosteroid and IVIG. For HCV treatment induced ITP, changed platelet criteria to <75,000. Re-auth: added general efficacy statement and max dose requirement for each indication; removed certain monitoring criteria.	03.17	03.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
For chronic ITP: added requirement for splenectomy unless member has contraindications to surgery; modified requirement related to platelet count to also include active bleed.	07.17	08.17
1Q18 annual review: - Policies combined for Centene Medicaid and Commercial lines of business. New policy for Marketplace line of business. -No significant change from previous corporate approved policy. - Added age restriction per PI. - Commercial: for chronic ITP-added requirements related to specialist involvement, insufficient response to corticosteroids and immunoglobulins, splenectomy (unless member has contraindications to surgery), platelet count, and active bleed; for hepatitis-C associated thrombocytopenia, added requirements related to specialist involvement, concomitant use with interferon-based therapy, and platelet count; for aplastic anemia, added requirements related to specialist involvement and platelet count; modified initial approval duration from LOB to 6 months. On re-auth, added requirements related to platelet count < 400 x 10^9/L within the last 90 days, and for hepatitis C-associated thrombocytopenia, continuation of antiviral therapy; additional positive therapeutic response examples added; modified continued approval duration from LOB to 12 months, or 6 months for hepatitis C associated thrombocytopenia - References reviewed and updated.	11.14.17	02.18

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.