

PURPOSE OF THE POLICY

To define coverage criteria for Promacta (eltrombopag) and Nplate (romiplostim) for the treatment of chronic immune (idiopathic) thrombocytopenic purpura (ITP).

STATEMENT OF THE POLICY

Promacta (eltrombopag) and Nplate (romiplostim) will be covered, for new starts only, when the below criteria is met:

PROCEDURES

1. Initial review

- 1.1 All FDA approved indications, not otherwise excluded from Part D.
- 1.2 Documentation of an insufficient response or contraindications to the standard of care of immune idiopathic thrombocytopenic purpura, ex corticosteroids, immunoglobulins or splenectomy or if clinical condition increases the risk for bleeding.
- 1.3 Coverage of NPlate requires a trial and failure or contraindication to Promacta.

2. Exclusion

- 2.1 Coverage excluded if intent is to solely normalize platelet counts.

HISTORY

3/19/09 Kpezzino original policy

1/1/2010-Thowerton – policy to reflect CMS upload

1/1/2011-Thowerton-replaced criteria 1.2

1.1.2011-Thowerton-replaced crit 1.3 which was approved by CMS

1.1.2012-Thowerton-changed “and” statements to “or” per CMS Outlier Justifications