Pharmacy Drug Policy Checklist

POLICY NAME	Promacta (eltrombopag)	POLICY #	1866P

Criteria

Coverage Criteria

- ☐ **1.1** Diagnosis of persistent or chronic immune (idiopathic) thrombocytopenic purpura (ITP)
- ☐ **1.2** Prescribed by or in consultation with a hematologist (blood disorder doctor)
- ☐ **1.3** Age 1 year or older
- ☐ **1.4** Documentation of insufficient response or contraindications to previous therapies for ITP (corticosteroids, immunoglobulins, OR splenectomy)

Coverage Criteria for Severe Aplastic Anemia

- ☐ **2.1** Diagnosis of severe aplastic anemia, first-line treatment or refractory
  - For first-line therapy, use in combination with immunosuppressive therapy
- ☐ **2.2** Prescribed by or in consultation with a hematologist (blood disorder doctor)
- ☐ **2.3** Age 2 years or older for first-line treatment otherwise age 18 years or older for refractory therapy

Coverage for Chronic Hepatitis C Infection-Associated Thrombocytopenia

- ☐ **3.1** Diagnosis of Chronic Hepatitis C infection-associated thrombocytopenia
- ☐ **3.2** Prescribed by or in consultation with a hematologist (blood disorder doctor), hepatologist (liver doctor), gastroenterologist (doctor of the digestive system), or infectious disease specialist
- ☐ **3.3** Age 18 years or older
- ☐ **3.4** Promacta is being used to allow for the initiation and maintenance of interferon-based therapy

Exclusion Criteria – Any of the following prevents coverage

- ☐ **4.1** Coverage excluded if intent is to solely normalize platelet counts
- ☐ **4.2** Coverage excluded if member on regimen containing direct-acting antiviral agent