GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
THROMBOPOIESIS STIMULATING PROTEINS PA SUMMARY

Preferred	Non-Preferred
Doptelet (avatrombopag) Mulpleta (lusutrombopag) Promacta (eltrombopag olamine)	Alvaiz (eltrombopaq choline) Nplate (romisplostim) Tavalisse (fostamatinib)

LENGTH OF AUTHORIZATION: Varies

NOTES:

- Preferred and non-preferred agents require prior authorization (PA).
- **The criteria details below are for the outpatient pharmacy program.** If a medication is being administered in a physician's office or clinic, then the medication must be billed through the DCH physician services program and not the outpatient pharmacy program. Information regarding the physician services program is located at www.mmis.georgia.gov.

PA CRITERIA:

Doptelet

- Approvable for members 18 years of age or older with a diagnosis of thrombocytopenia (platelet count <50 $x10^9$/L within the past 14 days) due to chronic liver disease (CLD) who are scheduled to undergo an invasive procedure within the next 30 days and the medication must be started within 10-13 days of the scheduled procedure and the scheduled procedure must be performed within 5-8 days after the last dose of medication.
- Approvable for members 18 years of age or older with a diagnosis of thrombocytopenia due to chronic immune (idiopathic) thrombocytopenia purpura (ITP) who have had an insufficient response (platelet count <30 $x10^9$/L) to corticosteroid therapy, immunoglobulin therapy or splenectomy and have had an insufficient response (platelet count <30 $x10^9$/L), allergy, contraindication, drug-drug interaction or intolerable side effect to Promacta.

Mulpleta

- Approvable for members 18 years of age or older with a diagnosis of thrombocytopenia (platelet count <50 $x10^9$/L within the past 14 days) due to CLD who are scheduled to undergo an invasive procedure within the next 30 days.
- The medication must be started within 8-14 days of the scheduled procedure and the scheduled procedure must be performed within 2-8 days after the last dose of medication.

Promacta

- Approvable for members 1 year of age or older with a diagnosis of thrombocytopenia due to chronic immune (idiopathic) thrombocytopenia purpura (ITP) who have had an insufficient response (platelet count <30 $x10^9$/L) to corticosteroid therapy, immunoglobulin therapy or splenectomy.

- ❖ Approvable for members 18 years of age or older with a diagnosis of thrombocytopenia due to chronic hepatitis C (CHC) who are unable to start and maintain interferon therapy due to low platelet count (<75 x 10^9/L).
- ❖ Approvable for members 2 years of age or older with a diagnosis of severe aplastic anemia who will be using the medication in combination with immunosuppressive therapy as first-line therapy or who have had an insufficient response (platelet count <30 x10^9/L) to immunosuppressive therapy.
- ❖ In addition for the suspension formulation, member must be unable to swallow solid oral dosage formulations or require dosing unable to be obtained with the tablet formulation.

Alvaiz

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Promacta, is not appropriate for the member in addition to meeting the criteria for Promacta.

Nplate

- ❖ Approvable for members 1 to 17 years of age with a diagnosis of thrombocytopenia due to chronic immune (idiopathic) thrombocytopenia purpura (ITP) who have had an insufficient response (platelet count <30 x10^9/L) to corticosteroid therapy, immunoglobulin therapy or splenectomy and have had an insufficient response (platelet count <30 x10^9/L), allergy, contraindication, drug-drug interaction or intolerable side effect to Promacta.
- ❖ Approvable for members 18 years of age or older with a diagnosis of thrombocytopenia due to chronic immune (idiopathic) thrombocytopenia purpura (ITP) who have had an insufficient response (platelet count <30 x10^9/L) to corticosteroid therapy, immunoglobulin therapy or splenectomy and have had an insufficient response (platelet count <30 x10^9/L), allergies, contraindications, drug-drug interactions or intolerable side effects to Promacta and Doptelet.

Tavalisse

- ❖ Approvable for members 18 years of age or older with a diagnosis of thrombocytopenia due to chronic immune (idiopathic) thrombocytopenia purpura (ITP) who have had an insufficient response (platelet count <30 x10^9/L) to corticosteroid therapy, immunoglobulin therapy or splenectomy and have had an insufficient response (platelet count <30 x10^9/L), allergies, contraindications, drug-drug interactions or intolerable side effects to Promacta and Doptelet.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to

www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL list.