PROMACTA (ELTROMBOPAQ)

Products Affected

- PROMACTA

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| **Covered Uses**| *Indicated for the treatment of thrombocytopenia in adult or pediatric patients >1 year of age patients with chronic immune (idiopathic) thrombocytopenia purpura (ITP).  
*Treatment of thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy.  
*Treatment of patients with severe aplastic anemia. |
| **Exclusion Criteria** | *Promacta is not indicated for the treatment of patients with myelodysplastic syndrome (MDS).                                                                                                                    |
| **Required Medical Information** | *Clinically diagnosed with chronic (idiopathic) immune thrombocytopenic purpura (ITP).  
*Failure, intolerant, or contraindication to corticosteroids, immunoglobulins, or splenectomy.  
*Patient must have increased risk for bleeding with platelet count less than 30,000/cu mm.  
*Must have LFTs and CBC, including platelet count and peripheral blood smear, prior to initiation.  
*Max quantity for ITP diagnosis is one tablet per day.  
OR  
*Patient must have Hepatitis C and thrombocytopenia with platelet count less than 75,000/cu mm.  
*Promacta is being used to allow for the initiation and maintenance of interferon-based therapy.  
*Max quantity for thrombocytopenia with Hepatitis C is one tablet per day.  
OR  
*Clinically diagnosed with severe aplastic anemia.  
*Failure, intolerant, or contraindicated to immunosuppressive therapy.  
*Max quantity 3 tablets per day for severe aplastic anemia. |
| **Age Restrictions** | *Must be 1 year of age or older (ITP)                                                                                                                                  |
| **Prescriber Restrictions** | *Must be prescribed by a hematologist, oncologist, hepatologist, gastroenterologist, transplant specialist or infectious disease specialist.                                                                 |
| **Coverage Duration** | *Initial: 6 months  
*Renewal: 1 year                                                                                                                                           |

The criteria listed above applies to Fallon Health Plan and its subsidiaries.
Fallon Health Department of Pharmacy Services
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| **Other Criteria** | *Continuation of therapy criteria:  
Patient is tolerating treatment.  
Patient has disease stabilization or improvement in disease (as defined by standard parameters for the patient's condition).  
Patient has periodic LFTs and CBCs.  
Most recent Platelet count must be greater than 20,000/cu mm over baseline or between 50,000/cu mm to 400,000/cu mm for continued therapy.  
For Hepatitis C patients, Promacta may not be continued if antiviral therapy has been discontinued.  
Benefit Type: Pharmacy  
Adopted: 03/11/09  
Reviewed: 12/30/13, 12/10/14, 4/11/18 use criteria updated, age of use, exclusions updated, continuation criteria updated, removed Not approved if, Special considerations, quantity limits per Dx. |