Promacta® (eltrombopag)
(Oral)

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I. Length of Authorization

Coverage is provided for three months and may be renewed.

- Aplastic Anemia: Use in first-line therapy is limited to a maximum of 6 months of treatment (i.e., may be renewed one time only).
- Chronic hepatitis C: use is limited to a maximum of 48 weeks of treatment (in combination with interferon)

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- 12.5 mg tablets – 1 tablet per day
- 25 mg tablets – 1 tablet per day
- 50 mg tablets – 1 tablet per day
- 75 mg tablets – 2 tablets per day
- 12.5 mg packet for oral suspension – 1 packet per day
- 25 mg packet for oral suspension – 3 packets per day

B. Max Units (per dose and over time) [HCPCS Unit]:

- 150 mg daily

III. Initial Approval Criteria [1,15-17]

Coverage is provided in the following conditions:

- Patient is at least 18 years of age, unless otherwise specified; **AND**

Universal Criteria [1]

- Patient is not on any other thrombopoietin receptor agonist or mimetic (e.g., romiplostim, avatrombopag, lusutrombopag, etc.) or fostamatinib; **AND**
- Laboratory values are current (i.e., drawn within the previous 28 days); **AND**

- Eltrombopag is not being used to attempt to normalize platelet count; **AND**

Chronic Immune (idiopathic) Thrombocytopenia (ITP) † Φ [1,2,6-9,13,18]

- Patient aged 1 year or older; **AND**
- Patient has had chronic ITP for at least 6 months (or meets the corticosteroid requirement below); **AND**
- Patient has previously failed any of the following treatments for ITP:
  - Patient has failed previous therapy with corticosteroids (i.e., patient had no response to at least a 3-month trial or is corticosteroid-dependent); **OR**
  - Patient has failed previous therapy with immunoglobulins; **OR**
  - Patient has had splenectomy; **AND**
- The patient is at increased risk for bleeding as indicated by platelet count of less than 30 × 10^9/L (30,000/mm^3)

Chronic Hepatitis C-associated Thrombocytopenia † [1,10,11]

- Patient will be initiating and/or continuing interferon-based therapy to treat chronic hepatitis C; **AND**
- Patient is diagnosed with thrombocytopenia as indicated by platelet count of less than 75 × 10^9/L (75,000/mm^3); **AND**
- The patient's degree of thrombocytopenia precludes administration of interferon-based therapy in the absence of eltrombopag

  Note: safety and efficacy have not been established in combination with direct-acting antiviral agents used without interferon

Severe Aplastic Anemia † Φ [1,3-5,12,14]

- Patient is diagnosed with severe aplastic anemia; **AND**
- Patient has one of the following:
  - Patient has bone marrow (BM) cellularity < 25%; **OR**
  - Patient has bone marrow (BM) cellularity < 50% if < 30% of BM is hematopoietic cells; **AND**
- Patient has at least two (2) of the following:
  - Peripheral blood neutrophil count < 0.5 x 10^9/L
  - Peripheral blood platelet count < 20 x 10^9/L
  - Peripheral blood reticulocyte count < 20 x 10^9/L; **AND**
- Used in one of the following treatment settings:
  - Used as first-line therapy; **AND**
    - Patient aged 2 years or older: **AND**
    - Patient has not received prior immunosuppressive therapy with antithymocyte globulin (ATG), alemtuzumab, or high-dose cyclophosphamide; **AND**

        - Used in combination with standard immunosuppressive therapy (i.e., antithymocyte globulin (ATG) and cyclosporine); **OR**
    - Used in refractory disease; **AND**
        - Patient has had at least a 3-month trial and failed previous therapy with ONE immunosuppressive therapy such as antithymocyte globulin, cyclosporine, or cyclophosphamide

Myelodysplastic Syndromes (MDS) ‡ [15-17,19]

- Patient has lower risk disease [i.e., IPSS-R (Very Low, Low, Intermediate), IPSS (Low/Intermediate-1), WPSS (Very Low, Low, Intermediate)]; **AND**
- Patient has severe or refractory thrombocytopenia (i.e., platelet count <30 x 10^9/L or higher with a history of bleeding); **AND**
- Patient progressed or had no response to hypomethylating agents (e.g., azacitidine, decitabine, etc.), immunosuppressive therapy, or clinical trial

† FDA Approved Indication(s); ‡ Compendia recommended indication(s); Φ Orphan Drug

IV. Renewal Criteria [1]

Coverage can be renewed based upon the following criteria:

- Patient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: hepatic decompensation in patients with chronic hepatitis C, hepatotoxicity (abnormal liver enzymes), risk of progression of myelodysplastic syndromes to acute myelogenous leukemia, thrombotic/thromboembolic complications (blood clots), cataracts, etc.; **AND**
- Platelet count (within the preceding 28 days) does not exceed 400 x 10^9/L; **AND**

ITP [1]

- Disease response indicated by the achievement and maintenance of a platelet count of at least 50 × 10^9/L as necessary to reduce the risk for bleeding

Chronic Hepatitis C-associated thrombocytopenia [1]

- Patient has not exceeded 48 weeks of therapy in combination with interferon; **AND**
- Continued administration is necessary in order to continue to receive interferon; **AND**

Aplastic Anemia [1]

- First-line therapy:
    - Patient has not received more than 6 months of treatment; **AND**

- Disease response indicated by two (2) or more of the following criteria on 2 consecutive serial blood count measurements at least one week apart:
  - Platelet count increases to 20 x 10^9/L
  - Hemoglobin greater than 10 g/dL
  - ANC increase greater than 0.5 x 10^9/L.
  - Reticulocyte count greater than 60,000/mcL

- Refractory disease: response indicated by one (1) or more of the following criteria on 2 consecutive serial blood count measurements at least one week apart:
  - Platelet count increases to 20 x 10^9/L above baseline, or stable platelet counts with transfusion independence for a minimum of 8 weeks
  - Hemoglobin increase by greater than 1.5 g/dL, or a reduction in greater than or equal to 4 units of RBC transfusions for 8 consecutive weeks
  - ANC increase of 100% or an ANC increase greater than 0.5 x 10^9/L.
  - Reticulocyte count greater than 60,000/mcL

MDS [15-17,19]

- Patient has not developed acute myeloid leukemia (AML); **AND**
- Disease response indicated by an increase in platelet count compared to pretreatment baseline, reduction in bleeding events, or reduction in platelet transfusion requirements

V. Dosage/Administration [1,15-17]

Indication	Dose
ITP	• Pediatric patients aged 1-5 years: initiate at a dose of 25 mg daily • Adults and pediatric patients 6 years and older: initiate at a dose of 50 mg daily. *Decrease initial dose to 25 mg for patients of Asian ancestry OR those with hepatic impairment (Child-Pugh Class A, B, C). Decrease initial dose to 12.5 mg for patients of Asian ancestry OR those with hepatic impairment (Child-Pugh Class A, B, C).* • Adjust to maintain platelet count greater than 50 x 10^9/L. Do not exceed 75mg daily.
Chronic Hepatitis C-associated Thrombocytopenia	Initiate at 25 mg daily. Do not exceed 100 mg daily • Administered in combination with an interferon-based regimen. Total duration of treatment is not to exceed 48 weeks
Severe Aplastic Anemia (First-line therapy)	Age 2-5 years: • 2.5 mg/kg once daily for 6 months. Total duration of treatment is 6 months. Age 6-11 years: • 75 mg once daily for 6 months. Total duration of treatment is 6 months. Age 12 years and older: • 150 mg once daily for 6 months. Total duration of treatment is 6 months.

	Decrease dose by 50% for patients of Asian ancestry or those with hepatic impairment (Child-Pugh Class A, B, C)
Refractory Severe Aplastic Anemia	Initiate at 50 mg once daily. Adjust the dose in 50-mg increments every 2 weeks to maintain platelet count greater than 50 x 10^9/L. Do not exceed 150 mg per day. *Decrease initial dose to 25 mg for patients of Asian ancestry or those with hepatic impairment (Child-Pugh Class A, B, C)*
MDS	Initiate at 100 mg per day. Do not exceed a maximum of 300 mg per day *Decrease dose by 50% for patients of Asian ancestry*

VI. Billing Code/Availability Information

HCPCS:

- J8499 – Prescription drug, oral, non-chemotherapeutic, Not Otherwise Specified

NDC:

- 12.5 mg tablets: 00078-0684-xx
- 25 mg tablets: 00078-0685-xx
- 50 mg tablets: 00078-0686-xx
- 75 mg tablets: 00078-0687-xx
- 12.5 mg packet for oral suspension: 00078-0972-xx
- 25 mg packet for oral suspension: 00078-0697-xx

VII. References

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19. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for eltrombopag. National Comprehensive Cancer Network, 2021. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to www.nccn.org/. Accessed January 2021.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
B18.2	Chronic viral hepatitis C
C93.10	Chronic myelomonocytic leukemia not having achieved remission
D46.0	Refractory anemia without ring sideroblasts, so stated
D46.1	Refractory anemia with ring sideroblasts
D46.20	Refractory anemia with excess of blasts, unspecified
D46.21	Refractory anemia with excess of blasts 1
D46.4	Refractory anemia, unspecified
D46.9	Myelodysplastic syndrome, unspecified
D46.A	Refractory cytopenia with multilineage dysplasia
D46.B	Refractory cytopenia with multilineage dysplasia and ring sideroblasts
D46.Z	Other myelodysplastic syndromes
D61.3	Idiopathic aplastic anemia
D61.9	Aplastic anemia, unspecified
D69.3	Immune thrombocytopenic purpura

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Articles (LCAs) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCA/LCD): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC