

Thrombopoietin Receptor Agonists and Tavalisse Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date
11-01-2025

Date of Origin

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Doptelet	avatrombopag maleate tab	20 MG	M ; N ; O ; Y	N		
Alvaiz	eltrombopag choline tab	18 MG ; 36 MG ; 54 MG ; 9 MG	M ; N ; O ; Y	N		
Promacta	eltrombopag olamine powder pack for susp ; eltrombopag olamine tab	12.5 MG ; 25 MG ; 50 MG ; 75 MG	M ; N ; O ; Y	O ; Y		
Promacta	Eltrombopag Olamine Tab 12.5 MG (Base Equiv)	12.5 MG	M ; N ; O ; Y	O ; Y		
Promacta	Eltrombopag Olamine Tab 25 MG (Base Equiv)	25 MG	M ; N ; O ; Y	O ; Y		
Promacta	Eltrombopag Olamine Tab 50 MG (Base Equiv)	50 MG	M ; N ; O ; Y	O ; Y		
Promacta	Eltrombopag Olamine Tab 75 MG (Base Equiv)	75 MG	M ; N ; O ; Y	O ; Y		
Tavalisse	fostamatinib disodium tab	100 MG ; 150 MG	M ; N ; O ; Y	N		
Mulpleta	lusutrombopag tab	3 MG	M ; N ; O ; Y	N		
Nplate	romiplostim for inj	125 MCG ; 250 MCG ; 500 MCG	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Alvaiz	eltrombopag choline tab	9 MG	30	Tablets	30	DAYS			
Alvaiz	eltrombopag choline tab	18 MG	30	Tablets	30	DAYS			
Alvaiz	eltrombopag choline tab	36 MG	60	Tablets	30	DAYS			
Alvaiz	eltrombopag choline tab	54 MG	60	Tablets	30	DAYS			

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Doptelet	Avatrombopag Maleate Tab 20 MG (Base Equiv)	20 MG	60	Tablets	30	DAYS			
Mulpleta	Lusutrombopag Tab 3 MG	3 MG	7	Tablets	7	DAYS			
Promacta	Eltrombopag Olamine Powder Pack for Susp 12.5 MG (Base Eq)	12.5 MG	30	Packets	30	DAYS			
Promacta	Eltrombopag Olamine Powder Pack for Susp 25 MG (Base Equiv)	25 MG	30	Packets	30	DAYS			
Promacta	Eltrombopag Olamine Tab 12.5 MG (Base Equiv)	12.5 MG	30	Tablets	30	DAYS			
Promacta	Eltrombopag Olamine Tab 25 MG (Base Equiv)	25 MG	30	Tablets	30	DAYS			
Promacta	Eltrombopag Olamine Tab 50 MG (Base Equiv)	50 MG	60	Tablets	30	DAYS			
Promacta	Eltrombopag Olamine Tab 75 MG (Base Equiv)	75 MG	60	Tablets	30	DAYS			
Tavalisse	fostamatinib disodium tab	100 MG ; 150 MG	60	Tablets	30	DAYS			

ADDITIONAL QUANTITY LIMIT INFORMATION

Wildcard	Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Additional QL Information	Targeted NDCs When Exclusions Exist	Effective Date	Term Date
824050600021	Nplate	romiplostim for inj	125 MCG ; 250 MCG ; 500 MCG	Max 10 mcg/kg/week			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Alvaiz	eltrombopag choline tab	18 MG ; 36 MG ; 54 MG ; 9 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ;

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Doptelet	avatrombopag maleate tab	20 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Mulpleta	lusutrombopag tab	3 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Nplate	romiplostim for inj	125 MCG ; 250 MCG ; 500 MCG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Promacta	eltrombopag olamine powder pack for susp ; eltrombopag olamine tab	12.5 MG ; 25 MG ; 50 MG ; 75 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Promacta	Eltrombopag Olamine Tab 12.5 MG (Base Equiv)	12.5 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Promacta	Eltrombopag Olamine Tab 25 MG (Base Equiv)	25 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Promacta	Eltrombopag Olamine Tab 50 MG (Base Equiv)	50 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Promacta	Eltrombopag Olamine Tab 75 MG (Base Equiv)	75 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Tavalisse	fostamatinib disodium tab	100 MG ; 150 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Alvaiz	eltrombopag choline tab	18 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Alvaiz	eltrombopag choline tab	9 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Alvaiz	eltrombopag choline tab	36 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Alvaiz	eltrombopag choline tab	54 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Doptelet	Avatrombopag Maleate Tab 20 MG (Base Equiv)	20 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Mupleta	Lusutrombopag Tab 3 MG	3 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Nplate	romiplostim for inj	125 MCG ; 250 MCG ; 500 MCG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Promacta	Eltrombopag Olamine Powder Pack for Susp 12.5 MG (Base Eq)	12.5 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Promacta	Eltrombopag Olamine Powder Pack for Susp 25 MG (Base Equiv)	25 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Promacta	Eltrombopag Olamine Tab 12.5 MG (Base Equiv)	12.5 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Promacta	Eltrombopag Olamine Tab 25 MG (Base Equiv)	25 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Promacta	Eltrombopag Olamine Tab 50 MG (Base Equiv)	50 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Promacta	Eltrombopag Olamine Tab 75 MG (Base Equiv)	75 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Tavalisse	fostamatinib disodium tab	100 MG ; 150 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Initial Evaluation</p> <p>Target Agent(s) will be approved when the ALL of the following are met:</p> <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The requested agent is Doptelet AND ONE of the following: <ol style="list-style-type: none"> 1. The patient has a diagnosis of chronic (defined as lasting for at least 12 months) immune (idiopathic) thrombocytopenia (ITP) AND BOTH of the following: <ol style="list-style-type: none"> A. ONE of the following: <ol style="list-style-type: none"> 1. The patient has a baseline (prior to therapy with the requested agent) platelet count less than or equal to $30 \times 10^9/L$ OR 2. The patient has a baseline (prior to therapy with the requested agent) platelet count greater than $30 \times 10^9/L$ but less than $50 \times 10^9/L$ AND has symptomatic bleeding and/or an increased risk for bleeding AND

Module	Clinical Criteria for Approval
	<p>B. ONE of the following:</p> <ol style="list-style-type: none"> 1. BOTH of the following: <ol style="list-style-type: none"> A. ONE of the following: <ol style="list-style-type: none"> 1. The prescriber has stated that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR 2. The prescriber has submitted documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer [chart notes are required] AND B. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR 2. The patient has tried and had an inadequate response to ONE corticosteroid used for the treatment of ITP OR 3. The patient has an intolerance or hypersensitivity to ONE corticosteroid used for the treatment of ITP OR 4. The patient has an FDA labeled contraindication to ALL corticosteroids used for the treatment of ITP OR 5. The patient has tried and had an inadequate response to another thrombopoietin receptor agonist (e.g., Nplate, Promacta) or Tavalisse OR 6. The patient has tried and had an inadequate response to immunoglobulins (IVIg or Anti-D) OR 7. The patient has had an inadequate response to a splenectomy OR 8. The patient has tried and had an inadequate response to rituximab OR <p>2. The patient has a diagnosis of thrombocytopenia and has chronic liver disease AND ALL of the following:</p> <ol style="list-style-type: none"> A. The patient has a baseline (prior to therapy with the requested agent) platelet count less than $50 \times 10^9/L$ AND B. The patient is scheduled to undergo a procedure with an associated risk of bleeding (e.g., gastrointestinal endoscopy, liver biopsy, bronchoscopy, dental procedure) AND C. The patient would require a platelet transfusion unless platelet counts are clinically increased from baseline (prior to therapy with the requested agent) OR <p>3. The patient has another FDA labeled indication for the requested agent and route of administration OR</p> <p>4. The patient has another indication that is supported in compendia for the requested agent and route of administration OR</p> <p>B. The requested agent is Mulpleta (lusutrombopag) AND ONE of the following:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of thrombocytopenia and has chronic liver disease AND ALL of the following: <ol style="list-style-type: none"> A. The patient has a baseline (prior to therapy with the requested agent) platelet count less than $50 \times 10^9/L$ AND B. The patient is scheduled to undergo a procedure with an associated risk of bleeding (e.g., gastrointestinal endoscopy, liver biopsy, bronchoscopy, dental procedure) AND C. The patient would require a platelet transfusion unless platelet counts are clinically increased from baseline (prior to therapy with the requested agent) OR

Module	Clinical Criteria for Approval
	<ul style="list-style-type: none"> 2. The patient has another FDA labeled indication for the requested agent and route of administration OR 3. The patient has another indication that is supported in compendia for the requested agent and route of administration OR C. The requested agent is Nplate (romiplostim) AND ONE of the following: <ul style="list-style-type: none"> 1. The patient has a diagnosis of hematopoietic syndrome of acute radiation syndrome (HS-ARS) OR 2. The patient has a diagnosis of immune (idiopathic) thrombocytopenia (ITP) AND ALL of the following: <ul style="list-style-type: none"> A. If the patient is a pediatric patient, then the patient has had ITP for at least 6 months AND B. ONE of the following: <ul style="list-style-type: none"> 1. The patient has a baseline (prior to therapy with the requested agent) platelet count less than or equal to $30 \times 10^9/L$ OR 2. The patient has a baseline (prior to therapy with the requested agent) platelet count greater than $30 \times 10^9/L$ but less than $50 \times 10^9/L$ AND has symptomatic bleeding and/or an increased risk for bleeding AND C. ONE of the following: <ul style="list-style-type: none"> 1. BOTH of the following: <ul style="list-style-type: none"> A. ONE of the following: <ul style="list-style-type: none"> 1. The prescriber has stated that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR 2. The prescriber has submitted documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer [chart notes are required] AND B. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR 2. The patient has tried and had an inadequate response to ONE corticosteroid used for the treatment of ITP OR 3. The patient has an intolerance or hypersensitivity to ONE corticosteroid used for the treatment of ITP OR 4. The patient has an FDA labeled contraindication to ALL corticosteroids used for the treatment of ITP OR 5. The patient has tried and had an inadequate response to immunoglobulins (IVIg or anti-D) OR 6. The patient has had an inadequate response to a splenectomy OR 7. The patient has tried and had an inadequate response to rituximab OR 3. The patient has another FDA labeled indication for the requested agent and route of administration OR 4. The patient has another indication that is supported in compendia for the requested agent and route of administration OR D. The requested agent is Promacta (eltrombopag) AND ONE of the following: <ul style="list-style-type: none"> 1. The patient has a diagnosis of hepatitis C associated thrombocytopenia AND ONE of the following: <ul style="list-style-type: none"> A. The intent of therapy with the requested agent is to increase platelet counts sufficiently to initiate interferon therapy AND the

Module	Clinical Criteria for Approval
	<p>patient's baseline (prior to therapy with the requested agent) platelet count is less than $75 \times 10^9/L$ OR</p> <p>B. The patient is on concomitant therapy with interferon AND is at risk for discontinuing hepatitis C therapy due to thrombocytopenia OR</p> <p>2. The patient has a diagnosis of severe aplastic anemia AND ALL of the following:</p> <p>A. The patient has at least 2 of the following baseline (prior to therapy with the requested agent) blood criteria:</p> <ol style="list-style-type: none"> 1. Neutrophils less than $0.5 \times 10^9/L$ 2. Platelets less than $30 \times 10^9/L$ 3. Reticulocyte count less than $60 \times 10^9/L$ AND <p>B. The patient has 1 of the following marrow criteria:</p> <ol style="list-style-type: none"> 1. Severe hypocellularity (i.e., less than 25%) OR 2. Moderate hypocellularity (i.e., 25-50%) with hematopoietic cells representing less than 30% of residual cells AND <p>C. ONE of the following:</p> <ol style="list-style-type: none"> 1. BOTH of the following: <ol style="list-style-type: none"> A. The patient will use the requested agent as first-line treatment AND B. The patient will use the requested agent in combination with standard immunosuppressive therapy (i.e., antithymocyte globulin [ATG] AND cyclosporine) OR 2. ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The prescriber has stated that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR B. The prescriber has submitted documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer [chart notes are required] AND 2. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR B. The patient has tried and had an inadequate response to BOTH antithymocyte globulin (ATG) AND cyclosporine therapy OR C. The patient has an intolerance or hypersensitivity to BOTH ATG AND cyclosporine OR D. The patient has an FDA labeled contraindication to BOTH ATG AND cyclosporine OR <p>3. The patient has a diagnosis of persistent or chronic (defined as lasting for at least 3 months) immune (idiopathic) thrombocytopenia (ITP) AND BOTH of the following:</p> <p>A. ONE of the following:</p>

Module	Clinical Criteria for Approval
	<ol style="list-style-type: none"> 1. The patient has a baseline (prior to therapy with the requested agent) platelet count less than or equal to $30 \times 10^9/L$ OR 2. The patient has a baseline (prior to therapy with the requested agent) platelet count greater than $30 \times 10^9/L$ but less than $50 \times 10^9/L$ AND has symptomatic bleeding and/or an increased risk for bleeding AND <p>B. ONE of the following:</p> <ol style="list-style-type: none"> 1. BOTH of the following: <ol style="list-style-type: none"> A. ONE of the following: <ol style="list-style-type: none"> 1. The prescriber has stated that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR 2. The prescriber has submitted documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer [chart notes are required] AND B. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR 2. The patient has tried and had an inadequate response to ONE corticosteroid used for the treatment of ITP OR 3. The patient has an intolerance or hypersensitivity to ONE corticosteroid used for the treatment of ITP OR 4. The patient has an FDA labeled contraindication to ALL corticosteroids used for the treatment of ITP OR 5. The patient has tried and had an inadequate response to immunoglobulins (IVIg or anti-D) OR 6. The patient has had an inadequate response to a splenectomy OR 7. The patient has tried and had an inadequate response to rituximab OR <ol style="list-style-type: none"> 4. The patient has another FDA labeled indication for the requested agent and route of administration OR 5. The patient has another indication that is supported in compendia for the requested agent and route of administration OR <p>E. The requested agent is Alvaiz (eltrombopag) AND ONE of the following:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of hepatitis C associated thrombocytopenia AND ONE of the following: <ol style="list-style-type: none"> A. The intent of therapy with the requested agent is to increase platelet counts sufficiently to initiate interferon therapy AND the patient's baseline (prior to therapy with the requested agent) platelet count is less than $75 \times 10^9/L$ OR B. The patient is on concomitant therapy with interferon AND is at risk for discontinuing hepatitis C therapy due to thrombocytopenia OR 2. The patient has a diagnosis of severe aplastic anemia AND ALL of the following: <ol style="list-style-type: none"> 1. The patient has at least 2 of the following baseline (prior to therapy with the requested agent) blood criteria: <ol style="list-style-type: none"> A. Neutrophils less than $0.5 \times 10^9/L$ B. Platelets less than $30 \times 10^9/L$

Module	Clinical Criteria for Approval
	<p>C. Reticulocyte count less than $60 \times 10^9/L$ AND</p> <p>2. The patient has 1 of the following marrow criteria:</p> <p>A. Severe hypocellularity (i.e., less than 25%) OR</p> <p>B. Moderate hypocellularity (i.e., 25-50%) with hematopoietic cells representing less than 30% of residual cells AND</p> <p>3. ONE of the following</p> <p>A. BOTH of the following:</p> <p>1. ONE of the following:</p> <p>A. The prescriber has stated that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR</p> <p>B. The prescriber has submitted documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer [chart notes are required] AND</p> <p>2. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR</p> <p>B. The patient has tried and had an inadequate response to BOTH antithymocyte globulin (ATG) AND cyclosporine therapy OR</p> <p>C. The patient has an intolerance or hypersensitivity to BOTH ATG AND cyclosporine OR</p> <p>D. The patient has an FDA labeled contraindication to BOTH ATG AND cyclosporine OR</p> <p>3. The patient has a diagnosis of persistent or chronic (defined as lasting for at least 3 months) immune (idiopathic) thrombocytopenia (ITP) AND BOTH of the following:</p> <p>1. ONE of the following:</p> <p>A. The patient has a baseline (prior to therapy with the requested agent) platelet count less than or equal to $30 \times 10^9/L$ OR</p> <p>B. The patient has a baseline (prior to therapy with the requested agent) platelet count greater than $30 \times 10^9/L$ but less than $50 \times 10^9/L$ AND has symptomatic bleeding and/or an increased risk for bleeding AND</p> <p>2. ONE of the following:</p> <p>A. BOTH of the following:</p> <p>1. ONE of the following:</p> <p>A. The prescriber has stated that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR</p> <p>B. The prescriber has submitted documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced</p>

Module	Clinical Criteria for Approval
	<p style="text-align: center;">metastatic cancer [chart notes are required] AND</p> <ol style="list-style-type: none"> 2. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR B. The patient has tried and had an inadequate response to ONE corticosteroid used for the treatment of ITP OR C. The patient has an intolerance or hypersensitivity to ONE corticosteroid used for the treatment of ITP OR D. The patient has an FDA labeled contraindication to ALL corticosteroids used for the treatment of ITP OR E. The patient has tried and had an inadequate response to immunoglobulins (IVIg or anti-D) OR F. The patient has had an inadequate response to a splenectomy OR G. The patient has tried and had an inadequate response to rituximab OR 3. The patient has another FDA labeled indication for the requested agent and route of administration OR 4. The patient has another indication that is supported in compendia for the requested agent and route of administration OR <p>F. The requested agent is Tavalisse (fostamatinib disodium hexahydrate) AND ONE of the following:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of chronic (defined as lasting for at least 12 months) immune (idiopathic) thrombocytopenia (ITP) AND BOTH of the following: <ol style="list-style-type: none"> A. ONE of the following: <ol style="list-style-type: none"> 1. The patient has a baseline (prior to therapy with the requested agent) platelet count less than or equal to $30 \times 10^9/L$ OR 2. The patient has a baseline (prior to therapy with the requested agent) platelet count greater than $30 \times 10^9/L$ but less than $50 \times 10^9/L$ AND has symptomatic bleeding and/or an increased risk for bleeding AND B. ONE of the following: <ol style="list-style-type: none"> 1. BOTH of the following: <ol style="list-style-type: none"> A. ONE of the following: <ol style="list-style-type: none"> 1. The prescriber has stated that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR 2. The prescriber has submitted documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer [chart notes are required] AND B. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR 2. The patient has tried and had an inadequate response to ONE corticosteroid used for the treatment of ITP OR

Module	Clinical Criteria for Approval																																		
	<p>3. The patient has an intolerance or hypersensitivity to ONE corticosteroid used for the treatment of ITP OR</p> <p>4. The patient has an FDA labeled contraindication to ALL corticosteroids used for the treatment of ITP OR</p> <p>5. The patient has tried and had an inadequate response to another thrombopoietin receptor agonist (e.g., Doptelet, Nplate, Promacta) OR</p> <p>6. The patient has tried and had an inadequate response to immunoglobulins (IVIg or Anti-D) OR</p> <p>7. The patient has had an inadequate response to a splenectomy OR</p> <p>8. The patient has tried and had an inadequate response to rituximab OR</p> <p>2. The patient has another FDA labeled indication for the requested agent and route of administration OR</p> <p>3. The patient has another indication that is supported in compendia for the requested agent and route of administration AND</p> <p>2. If the patient has an FDA approved indication, ONE of the following:</p> <p>A. The patient's age is within FDA labeling for the requested indication for the requested agent OR</p> <p>B. There is support for using the requested agent for the patient's age for the requested indication AND</p> <p>3. ONE of the following:</p> <p>1. The patient will NOT be using the requested agent in combination with another agent included in this program OR</p> <p>2. The patient will use the requested agent in combination with another agent included in this program AND BOTH of the following:</p> <p>1. The requested agent is Nplate AND</p> <p>2. The patient has a diagnosis of hematopoietic syndrome of acute radiation syndrome (HS-ARS) AND</p> <p>4. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p>Compendia Allowed: AHFS, DrugDex 1, 2A, or 2B level of evidence, or NCCN 1, 2A, or 2B recommended use</p> <p>Initial Lengths of Approval:</p> <table border="1" data-bbox="228 1276 1424 1984"> <thead> <tr> <th data-bbox="228 1276 500 1339"></th> <th data-bbox="500 1276 743 1339">BCBSOK</th> <th data-bbox="743 1276 987 1339">BCBSIL and BCBSMT</th> <th data-bbox="987 1276 1230 1339">BCBSNM</th> <th data-bbox="1230 1276 1424 1339">All other Plans</th> </tr> </thead> <tbody> <tr> <td colspan="5" data-bbox="228 1339 1424 1371">Doptelet</td> </tr> <tr> <td data-bbox="228 1371 310 1633">Thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure</td> <td data-bbox="310 1371 500 1633">36 months</td> <td data-bbox="500 1371 743 1633">12 months</td> <td data-bbox="743 1371 987 1633">3 months</td> <td data-bbox="987 1371 1424 1633">1 month</td> </tr> <tr> <td data-bbox="228 1633 310 1696">All other indications</td> <td data-bbox="310 1633 500 1696">36 months</td> <td data-bbox="500 1633 743 1696">12 months</td> <td data-bbox="743 1633 987 1696">6 months</td> <td data-bbox="987 1633 1424 1696">6 months</td> </tr> <tr> <td colspan="5" data-bbox="228 1696 1424 1728">Mulpleta</td> </tr> <tr> <td data-bbox="228 1728 310 1984">Thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure</td> <td data-bbox="310 1728 500 1984">36 months</td> <td data-bbox="500 1728 743 1984">12 months</td> <td data-bbox="743 1728 987 1984">3 months</td> <td data-bbox="987 1728 1424 1984">1 month</td> </tr> </tbody> </table>						BCBSOK	BCBSIL and BCBSMT	BCBSNM	All other Plans	Doptelet					Thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure	36 months	12 months	3 months	1 month	All other indications	36 months	12 months	6 months	6 months	Mulpleta					Thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure	36 months	12 months	3 months	1 month
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Module	Clinical Criteria for Approval				
	All other indications	36 months	12 months	6 months	6 months
	Promacta				
	ITP	36 months	12 months	3 months	2 months
	Thrombocytopenia in Hep C	36 months	12 months	3 months	3 months
	First-Line therapy in severe aplastic anemia	36 months	12 months	6 months	6 months
	All other severe aplastic anemia	36 months	12 months	4 months	4 months
	All other indications	36 months	12 months	6 months	6 months
	Nplate				
	HR-ARS	36 months	12 months	3 months	1 time
	ITP	36 months	12 months	3 months	4 months
	All other indications	36 months	12 months	6 months	6 months
	Tavalisse				
	All indications	36 months	12 months	6 months	6 months
	Alvaiz				
	ITP	36 months	12 months	6 months	2 months
	Thrombocytopenia in Hep C	36 months	12 months	6 months	3 months
	All other severe aplastic anemia	36 months	12 months	6 months	4 months
	All other indications	36 months	12 months	6 months	6 months

The requested agent will also be approved when the following are met:

1. The request is for a BCBS MT Fully Insured or MT HIM member **AND**
 - A. The patient is under the age of 18 years old **AND**
 - B. The patient does NOT have any FDA labeled contraindications to the requested agent **AND**
 - C. The patient has an indication that is supported in TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] **AND**
 - D. There is support for an age in the patient's given age bracket in TWO articles from major peer-reviewed professional medical journals as generally safe and effective. The age brackets are: 1. infancy (birth up to, but not including, 2 years of age), 2. childhood (2 years of age through 11 years of age), 3. adolescence (12 years of age through 17 years of age). Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required]
- OR**

Module	Clinical Criteria for Approval
	<p>2. ALL of the following:</p> <ul style="list-style-type: none"> A. The member resides in Ohio AND B. The plan is Fully Insured or HIM Shop (SG) AND C. The patient does NOT have any FDA labeled contraindications to the requested agent AND D. ONE of the following: <ul style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ul style="list-style-type: none"> 1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process. [Note: patients not previously approved for the requested agent will require initial evaluation review]. (Doptelet and Mulpleta for thrombocytopenia with chronic liver disease AND Nplate for hematopoietic syndrome of acute radiation syndrome (HS-ARS) should always be reviewed under initial criteria.) AND 2. ONE of the following: <ul style="list-style-type: none"> A. The patient has a diagnosis of immune (idiopathic) thrombocytopenia (ITP) AND ONE of the following: <ul style="list-style-type: none"> 1. The patient's platelet count is greater than or equal to $50 \times 10^9/L$ OR 2. The patient's platelet count has increased sufficiently to avoid clinically significant bleeding OR B. The patient has the diagnosis of hepatitis C associated thrombocytopenia AND BOTH of the following: <ul style="list-style-type: none"> 1. The patient will be initiating or maintaining hepatitis C therapy with interferon AND 2. ONE of the following: <ul style="list-style-type: none"> A. The patient's platelet count is greater than or equal to $90 \times 10^9/L$ OR B. The patient's platelet count has increased sufficiently to initiate or maintain interferon therapy for the treatment of hepatitis C OR C. The patient has a diagnosis other than ITP or hepatitis C associated thrombocytopenia AND has had clinical benefit with the requested agent AND

Module	Clinical Criteria for Approval
	<p>3. The patient will NOT be using the requested agent in combination with another agent included in this program AND</p> <p>4. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p>Compendia Allowed: AHFS, DrugDex 1, 2A, or 2B level of evidence, or NCCN 1, 2A, or 2B recommended use</p> <p>Lengths of approval:</p> <p>BCBSOK: 36 months BCBSIL and BCBSMT: 12 months</p> <p>All other plans: Thrombocytopenia in hepatitis C: 6 months All other indications for the requested agent: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p>

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication OR B. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication AND 2. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit OR C. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication <p>Initial Lengths of Approval:</p> <p>BCBSIL: 12 months</p> <p>All other plans: Doptelet: thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure - 1 month; all other indications - 6 months Mulpleta: thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure - 1 month; all other indications - 6 months Nplate: HS-ARS - 1 time; ITP - 4 months; all other indications - 6 months Promacta: ITP - 2 months; thrombocytopenia in hep C - 3 months; first-line therapy in severe aplastic anemia - 6 months; all other severe aplastic anemia - 4 months; all other indications - 6 months Alvaiz: ITP - 2 months; thrombocytopenia in hep C - 3 months; all other severe aplastic anemia - 4 months; all other indications - 6 months Tavalisse: all indications - 6 months</p>

Module	Clinical Criteria for Approval
	<p>Renewal Lengths of Approval:</p> <p>BCBSIL: 12 months All other plans: thrombocytopenia in hepatitis C - 6 months; all other indications - 12 months</p>