# PRIOR AUTHORIZATION POLICY

**POLICY:** Thrombocytopenia – Doptelet Prior Authorization Policy
- Doptelet® (avatrombopag tablets – Dova/AkaRx)

**REVIEW DATE:** 04/12/2023

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***INSTRUCTIONS FOR USE***

*THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.*

## CIGNA NATIONAL FORMULARY COVERAGE:

### OVERVIEW

Doptelet, a thrombopoietin receptor agonist, is indicated for the following uses:[1]
- **Immune thrombocytopenia (ITP)**, chronic for treatment in adults who have had an insufficient response to a previous treatment.
- **Thrombocytopenia,** as treatment in adults with **chronic liver disease** who are scheduled to undergo a procedure.

For chronic ITP, Doptelet should be discontinued if the platelet count does not increase to ≥ 50 x $10^9$/L within 4 weeks at the maximum dose of 40 mg once daily. The safety and efficacy of Doptelet have not been established in pediatric patients. For chronic liver disease in patients undergoing a procedure, Doptelet is given as a 5-day course beginning 10 to 13 days before the scheduled procedure. In general, patients in the pivotal studies had a platelet count < 50 x $10^9$/L.

### Guidelines

In 2019, the American Society of Hematology updated guidelines for ITP.[4] Doptelet is not addressed specifically, but there are several recommendations. For adults with ITP for at least 3 months who are corticosteroid-dependent or unresponsive to corticosteroid, a thrombopoietin receptor agonist (either Promacta® [eltrombopag tablets and oral suspension] or Nplate® [romiplostim subcutaneous injection]) or a splenectomy are recommended. In children with newly diagnosed ITP who have non-

life-threatening mucosal bleeding, corticosteroids are recommended. For children who have non-life-threatening mucosal bleeding and did not respond to first-line treatment, thrombopoietin receptor agonists are recommended. Other treatment options in children and adults include intravenous immunoglobulin, anti-D immunoglobulin, and rituximab.

## POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Doptelet. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Doptelet as well as the monitoring required for adverse events and long-term efficacy, approval may require Doptelet to be prescribed by or in consultation with a physician who specializes in the condition being treated in certain indications.

**Doptelet® (avatrombopag tablets ( Dova/AkaRx) is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):**

**FDA-Approved Indications**

1. **Chronic Immune Thrombocytopenia.** Approve if the patient meets the following criteria (A or B):
   - **A)** Initial Therapy. Approve for 3 months if the patient meets all of the following (i, ii, iii, and iv):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Patient meets one of the following criteria (a or b):
       - **a)** Patient has a platelet count < 30 x $10^9$/L (< 30,000/mcL); OR
       - **b)** Patient meets both of the following criteria [(1) and (2)]:
         - **(1)** Patient has a platelet count < 50 x $10^9$/L (< 50,000/mcL); AND
         - **(2)** According to the prescriber, the patient is at an increased risk of bleeding; AND
     - **iii.** Patient meets one of the following criteria (a or b):
       - **a)** Patient has tried at least one other therapy; OR
         Note: Examples of therapies are systemic corticosteroids, intravenous immunoglobulin, anti-D immunoglobulin, Promacta (eltrombopag tablets and oral suspension), Nplate (romiplostim subcutaneous injection), Tavalisse (fostamatinib tablets), and rituximab.
       - **b)** Patient has undergone splenectomy; AND
     - **iv.** The medication is prescribed by or in consultation with a hematologist; OR
   - **B)** Patient is Currently Receiving Doptelet. Approve for 1 year if the patient meets both of the following criteria: (i and ii):
     - **i.** According to the prescriber, the patient demonstrates a beneficial clinical response; AND
       Note: A beneficial response can include increased platelet counts, maintenance of platelet counts, and/or a decreased frequency of bleeding episodes.
     - **ii.** Patient remains at risk for bleeding complications.

2. **Thrombocytopenia in a Patient with Chronic Liver Disease.** Approve for 5 days if the patient meets the following criteria (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has a current platelet count < 50 x $10^9$/L (< 50,000/mcL); AND
   C) Patient is scheduled to undergo a procedure within 10 to 13 days after starting Doptelet therapy.

## CONDITIONS NOT COVERED

**Doptelet® (avatrombopag tablets ( Dova/AkaRx)**
**is(are) considered experimental, investigational or unproven for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):**

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

## REFERENCES


1. Doptelet® tablets [prescribing information]. Durham, NC: AkaRx/Dova; July 2021.
2. Neunert C, Terrell DR, Arnold DM, et al. American Society of Hematology 2019 guidelines for immune thrombocytopenia. *Blood Adv*. 2019;3(23):3829-3866.


## HISTORY

| Type of Revision | Summary of Changes | Review Date |
|---|---|---|
| Annual Revision | **Chronic Immune Thrombocytopenia:** The wording to "Continuation of Therapy" was changed to "Patient is Currently Receiving Doptelet". | 03/23/2022 |
| Annual Revision | No criteria changes. | 04/12/2023 |