UnitedHealthcare Community Plan

# Clinical Pharmacy Program Guidelines for Doptelet

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| Program | Prior Authorization |
| Medication | Doptelet (avatrombopag) |
| Markets in Scope | California, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania- CHIP, Rhode Island, South Carolina |
| Issue Date | 8/2018 |
| Pharmacy and Therapeutics Approval Date | 8/2020 |
| Effective Date | 10/2020 |

## 1. Background:

Doptelet (avatrombopag) is a thrombopoietin receptor agonist indicated for the treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure. Doptelet is also indicated for the treatment of adult patients with chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment.

## 2. Coverage Criteria:

**A. <u>Thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure</u>**

1. **Doptelet** will be approved based on **<u>all</u>** of the following criteria:

   a. Diagnosis of thrombocytopenia

   **-AND-**

   b. Patient has chronic liver disease

   **-AND-**

   c. Patient is scheduled to undergo a procedure

   **-AND-**

d. History of failure, contraindication, or intolerance to Mulpleta (lusutrombopag)

**Authorization will be issued for 1 month.**

**B. Chronic Immune Thrombocytopenia (ITP)**

**1. Initial Authorization**

a. Diagnosis of chronic immune thrombocytopenia (ITP)

**-AND-**

b. **One** of the following:

(1) **Both** of the following:

(a) History of failure, contraindication, or intolerance to at least one of the following:

- Corticosteroids
- Immunoglobulins

**-AND-**

(b) History of failure, contraindication, or intolerance to Promacta (eltrombopag)

**-OR-**

(2) Patient is currently on Doptelet therapy

**Authorization will be issued for 12 months.**

**2. Reauthorization**

a. Documentation of positive clinical response to Doptelet therapy

**Authorization will be issued for 12 months.**

**3. Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits and/or Step Therapy may be in place.

## 4. References:


1. Doptelet [package insert]. Durham, NC: AkaRx, Inc.; June 2019.
2. Mulpleta [package insert]. Florham Park, NJ: Shionogi Inc.; May 2019.
3. Promacta [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2019.


| Program | Prior Authorization –Doptelet (avatrombopag) |
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| **Change Control** | |
| Date | Change |
| 8/2018 | New Program |
| 1/2019 | Added step through Mulpleta prior to receiving Doptelet. Updated references. |
| 8/2019 | Updated background and criteria to reflect new indication for ITP. Updated references. |
| 8/2020 | Annual review with no changes to coverage criteria. Added clinical rules section. |