



UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

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| Program Number    | 2022 P 1250-5                          |
| Program           | Prior Authorization/Notification       |
| Medication        | Doptelet <sup>®</sup> (avatrombopag)   |
| P&T Approval Date | 8/2018, 8/2019, 8/2020, 8/2021, 1/2022 |
| Effective Date    | 4/1/2022;<br>Oxford only: 4/1/2022     |

**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. Thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure**

1. Doptelet will be approved based on **all** of the following criteria:

a. Diagnosis of thrombocytopenia

-AND-

b. Patient has chronic liver disease

-AND-

c. Patient is scheduled to undergo a procedure

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

**B. Chronic immune thrombocytopenia (ITP)**

1. **Initial Authorization**

a. Doptelet will be approved based on **both** of the following criteria

(1) Diagnosis of chronic immune thrombocytopenia (ITP)

-AND-

(2) Patient has had an insufficient response to a previous treatment (e.g.,

corticosteroids, immunoglobulins, thrombopoietin receptor agonists, splenectomy)

**Authorization will be issued for 6 months**

**2. Reauthorization**

a. **Doptelet** will be approved based on the following criterion:

(1) 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.; July 2021.

| Program               | Prior Authorization/Notification - Doptelet (avatrombopag)                        |
|-----------------------|---|
| <b>Change Control</b> |   |
| 8/2018                | New program.  |
| 8/2019                | Updated background and criteria with new indication in ITP.<br>Updated reference. |
| 8/2020                | Annual review with no changes to coverage criteria.                               |
| 8/2021                | Annual review with no changes to coverage criteria. Updated reference.            |
| 1/2022                | Revised try/fail criteria to insufficient response. Updated reference.            |