

## **Clinical Policy: Romiplostim (Nplate)**

Reference Number: CP.PHAR.179

Effective Date: 03.01.16

Last Review Date: 02.20

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Romiplostim (Nplate<sup>®</sup>) is a thrombopoietin receptor agonist.

### **FDA Approved Indication(s)**

Nplate is indicated for the treatment of thrombocytopenia in:

- Adult patients with immune thrombocytopenia (ITP) who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy;
- Pediatric patients 1 year of age and older with ITP for at least 6 months who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy.

Limitation(s) of use:

- Nplate is not indicated for the treatment of thrombocytopenia due to myelodysplastic syndrome or any cause of thrombocytopenia other than ITP.
- Nplate should be used only in patients with ITP whose degree of thrombocytopenia and clinical condition increases the risk for bleeding.
- Nplate should not be used in an attempt to normalize platelet counts.

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Nplate is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Immune Thrombocytopenia (must meet all):**

1. Diagnosis of ITP;
2. Prescribed by or in consultation with a hematologist;
3. Age  $\geq$  1 year;
4. Current (within 30 days) platelet count is  $<$  30,000/ $\mu$ L or member has an active bleed;
5. Member meets one of the following (a or b):
  - a. Failure of a systemic corticosteroid;
  - b. Member has intolerance or contraindication to systemic corticosteroids, and failure of an immune globulin, unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);  
*\*Prior authorization may be required for immune globulins*
6. Dose does not exceed 10 mcg/kg per week.

**Approval duration: 6 months**

**B. Myelodysplastic Syndromes (off-label) (must meet all):**

1. Diagnosis of myelodysplastic syndromes (MDS);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Member has lower-risk MDS (IPSS-R (Very Low, Low, Intermediate), IPSS (Low/Intermediate-1), WPSS (Very Low, Low, Intermediate));
4. Member has severe or refractory thrombocytopenia following disease progression or no response to hypomethylating agents (e.g., azacitadine, decitabine), immunosuppressive therapy (e.g., Atgam<sup>®</sup>, cyclosporine), or clinical trial;
5. Request meets one of the following (a or b):\*
  - a. Dose does not exceed 10 mcg/kg per week;
  - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

*\*Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration: 6 months**

**C. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Immune Thrombocytopenia (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy (e.g., increase in platelet count from baseline, reduction in bleeding events);
3. Current (within the last 90 days) platelet count is < 400,000/ $\mu$ L;
4. If request is for a dose increase, new dose does not exceed 10 mcg/kg per week.

**Approval duration: 12 months**

**B. Myelodysplastic Syndromes (must meet all):**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Nplate for MDS and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):\*
  - a. New dose does not exceed 10 mcg/kg per week;
  - b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

*\*Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration: 12 months**

**C. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.  
**Approval duration: Duration of request or 6 months (whichever is less);** or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents;

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

IPSS: International Prognostic Scoring System

IPSS-R: Revised International Prognostic Scoring System

ITP: chronic immune thrombocytopenia

MDS: myelodysplastic syndromes

WPSS: WHO Classification-based Prognostic Scoring System

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<b>Corticosteroids*</b>		
dexamethasone	<p><b>ITP</b>  <u>Oral dosage:</u>  <i>Adults:</i> Initially, 0.75 to 9 mg/day PO, given in 2 to 4 divided doses. Adjust according to patient response.  <i>Children and adolescents:</i> 0.02 to 0.3 mg/kg/day PO or 0.6 to 9 mg/m<sup>2</sup>/day PO, given in 3 to 4 divided doses</p> <p><u>Intramuscular or intravenous dosage:</u>  <i>Adults:</i> Initially, 0.5 to 9 mg/day IV or IM, given in 2 to 4 divided doses. Adjust according to patient response.  <i>Children:</i> 0.02 to 0.3 mg/kg/day or 0.6 to 9 mg/m<sup>2</sup>/day IV or IM given in 3-4</p>	Dosage must be individualized and is highly variable depending on the nature and severity of the disease, route of treatment, and on patient response.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	divided doses. Adjust according to patient response.	
methylprednisolone	<p><b>ITP</b>  <u>Oral dosage:</u>  <i>Adults:</i> 4 to 48 mg/day PO in 4 divided doses. Adjust according to patient response.  <i>Children:</i> 0.5 to 1.7 mg/kg/day PO in divided doses every 6 to 12 hrs</p> <p><u>Intravenous dosage:</u>  <i>Adults:</i> 10 to 40 mg IV every 4 to 6 hours for up to 72 hours  <i>Children:</i> 0.11 to 1.6 mg/kg/day IV in 3 or 4 divided doses.</p>	Dosage must be individualized and is highly variable depending on the nature and severity of the disease, route of treatment, and on patient response.
prednisone	<p><b>ITP</b>  <i>Adults:</i> Initially, 1 mg/kg PO once daily; however, lower doses of 5 mg/day to 10 mg/day PO are preferable for long-term treatment.</p>	Dosage must be individualized and is highly variable depending on the nature and severity of the disease, route of treatment, and on patient response.
<b>Immune globulins</b>		
immune globulins (Carimune <sup>®</sup> NF, Flebogamma <sup>®</sup> DIF 10%, Gammagard <sup>®</sup> S/D, Gammaked <sup>™</sup> , Gamunex <sup>®</sup> -C, Gammaplex <sup>®</sup> , Octagam <sup>®</sup> 10%, Privigen <sup>®</sup> )	<p><b>ITP</b>  Refer to prescribing information</p>	Refer to prescribing information

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*\*Examples of corticosteroids/immunosuppressive agents provided are not all inclusive*

*Appendix C: Contraindications/Boxed Warnings*

None reported

*Appendix D: General Information*

- MDS prognostic scoring system online calculators are available below:
  - IPSS-R: <https://www.mds-foundation.org/ipss-r-calculator/>

- IPSS: [https://qxmd.com/calculate/calculator\\_123/mds-intnl-prognostic-scoring-sys-ipss](https://qxmd.com/calculate/calculator_123/mds-intnl-prognostic-scoring-sys-ipss)
- WPSS: [https://qxmd.com/calculate/calculator\\_143/mds-who-classification-based-prognostic-scoring-system-wpss](https://qxmd.com/calculate/calculator_143/mds-who-classification-based-prognostic-scoring-system-wpss)

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
ITP	The initial dose is 1 mcg/kg SC once weekly based on actual body weight. Adjust weekly dose by increments of 1 mcg/kg to achieve and maintain a platelet count $\geq$ 50,000/ $\mu$ L as necessary to reduce the risk for bleeding. Do not dose if platelet count is $>$ 400,000/ $\mu$ L.	10 mcg/kg/week

**VI. Product Availability**

Lyophilized powder in single-dose vials for injection: 125 mcg, 250 mcg, 500 mcg

**VII. References**

1. Nplate Prescribing Information. Thousand Oaks, CA: Amgen Inc.; October 2019. Available at <https://www.nplate.com/>. Accessed October 28, 2019.
2. Neunert C, Lim W, Crowther M, et al. The American Society of Hematology 2011 evidence-based practice guideline for immune thrombocytopenia. Blood. 2011; 117(16): 4190-4207.
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. Available at: <http://www.clinicalpharmacology-ip.com/>.
4. National Comprehensive Cancer Network. Myelodysplastic Syndromes Version 1.2020. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/mds.pdf](https://www.nccn.org/professionals/physician_gls/pdf/mds.pdf). Accessed November 19, 2019.
5. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [http://www.nccn.org/professionals/drug\\_compendium](http://www.nccn.org/professionals/drug_compendium). Accessed November 19, 2019.

**Coding Implications**

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2796	Injection, romiplostim, 10 mcg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy converted to new template and split from CP.PHAR.53. TPO RAs. Criteria: age added per PI; documentation requests removed; changed all approval periods to 3 and 6 months; changed platelet	03.16	03.16

Reviews, Revisions, and Approvals	Date	P&T Approval Date
criteria from <30,000 platelets at time of diagnosis to current platelet count <50,000.		
Criteria: initial-removed age restriction. Added requirement for a hematologist to be involved in care. For Chronic ITP, changed platelet criteria to <30, and modified trial to require the use of the 2 first line agents: corticosteroid and IVIG. Certain conditions representing safety criteria removed as the PI does not specify a test/ objective method by which they should be evaluated. Retained verifiable lab finding useful to assess need for therapy and continuation of therapy	03.17	03.17
Added requirement for splenectomy unless member has contraindications to surgery; modified requirement related to platelet count to also include active bleed.	07.17	08.17
1Q18 annual review: Policies combined for Centene Medicaid and Commercial lines of business. New policy for Marketplace line of business; No significant changes from previous corporate approved policy; Added age restriction per PI as safety and effectiveness in pediatric patients (< 18 years) have not been established; Commercial: added requirements related to specialist involvement, insufficient response to corticosteroids and immunoglobulins, splenectomy (unless member has contraindications to surgery), and platelet count or active bleed; re-auth: added platelet count < 400 x 10 <sup>9</sup> /L within the last 90 days; modified initial/continued approval duration from 6 months or to member’s renewal period (whichever is longer)/LOB to 6/12 months; Medicaid: Removed “other causes (e.g., myelodysplastic syndrome) of thrombocytopenia has been ruled out with documentation supporting that ITP is not due to any other causes” since specialist is involved in care; References reviewed and updated.	11.15.17	02.18
Removed requirement related to splenectomy based on specialist feedback	08.20.18	11.18
1Q 2019 annual review: added requirement that initial platelet counts be current (within 30 days); for cont tx approval, clarified that member must be continuing on interferon-based therapy; added MDS and other causes of thrombocytopenia other than chronic ITP as diagnoses not covered per package insert; no significant changes; references reviewed and updated.	10.30.18	02.19
No significant changes: updated FDA approved indication to include use in children one year of age and older (was previously labeled for adults only)	12.19.18	
1Q 2020 annual review: revised criteria to allow use in non-chronic ITP per revised prescribing information; revised systemic corticosteroid <i>and</i> immune globulin trial to tiered re-direction with	11.26.19	02.20

Reviews, Revisions, and Approvals	Date	P&T Approval Date
immune globulin trial only if corticosteroid cannot be used; removed MDS from excluded diagnoses and added criteria set as NCCN supported category 2A recommendation for use; references reviewed and updated.		

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.



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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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