

**CRITERIA FOR PRIOR AUTHORIZATION**

Promacta® (eltrombopag)

**PROVIDER GROUP** Pharmacy

**MANUAL GUIDELINES** The following drug requires prior authorization:  
 Eltrombopag (Promacta)

**CRITERIA FOR APLASTIC ANEMIA:** (must meet all of the following)

- Patient must have a diagnosis of severe aplastic anemia
- Patient must have had an inadequate response to immunosuppressive therapy
- Patient must be 18 years of age or older
- Must be prescribed by or consultation with a hematologist or oncologist

**CRITERIA FOR CHRONIC IMMUNE, IDIOPATHIC THROMBOCYTOPENIA (ITP):** (must meet all of the following)

- Patient must have a diagnosis of chronic immune, idiopathic thrombocytopenia
- Patient must have had an inadequate response to one of the following:
  - Corticosteroids
  - Immunoglobulins
  - Splenectomy
- Patient must be 6 years of age or older
- Must be prescribed by or consultation with a hematologist or oncologist

**CRITERIA FOR THROMBOCYTOPENIA IN HEPATITIS C:** (must meet all of the following)

- Patient must have a diagnosis of chronic hepatitis C with thrombocytopenia
- Patient must be on interferon-based therapy
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with a hematologist, hepatologist, or gastroenterologist

**LENGTH OF APPROVAL** 6 months

<b>Revision History</b>	
<b>Revision Date</b>	<b>Revision</b>
July 8, 2015	Update to include pediatric indication for ITP, ages 6 years and older
October 8, 2014	Add criteria for new indication of aplastic anemia
July 9, 2014	Add criteria requiring the use of interferon-based therapy for Hep C thrombocytopenia
July 10, 2013	Add criteria for new indication, thrombocytopenia in patients with chronic hepatitis C; remove criteria requiring patient and prescriber be enrolled in <i>Promacta Cares</i> program
July 8, 2009	Initial prior authorization criteria approved