Pharmacy Medical Necessity Guidelines: Thrombopoietin Receptor Agonists

Effective: February 1, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0988	

Note: For Tufts Health Plan Medicare Preferred Members, please refer to the Tufts Health Plan Medicare Preferred Prior Authorization Criteria. Background, applicable product and disclaimer information can be found on the last page.

OVERVIEW

Doptelet (avatrombopag tablet) 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
- Thrombocytopenia in adult patients with chronic immune thrombocytopenia who have had an insufficient response to a previous treatment

  Thrombocytopenia in pediatric patients 6 years and older with persistent or chronic immune thrombocytopenia who have had an insufficient response to a previous treatment

Doptelet Sprinkle (avatrombopag oral granule capsule) is a thrombopoietin receptor agonist indicated for the treatment of thrombocytopenia in pediatric patients 1 year to less than 6 years with persistent or chronic immune thrombocytopenia who have had an insufficient response to a previous treatment.

Mulpleta (lusutrombopag) 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.

Tavalisse (fostamatinib disodium hexahydrate) is a kinase inhibitor indicated for the treatment of adult patients with chronic immune thrombocytopenia who have had an insufficient response to a previous treatment.

COVERAGE GUIDELINES

Thrombocytopenia in Chronic Liver Disease

The plan may authorize coverage of **Doptelet tablets** or **Mulpleta** for members when **ALL** of the following criteria are met:

1. Documented diagnosis of severe thrombocytopenia as indicated by a baseline platelet count less than 50,000/mcL

AND

2. The patient is at least 18 years of age or older

AND

3. Documentation the patient has chronic liver disease

AND

4. Documentation the patient is scheduled to undergo a medical procedure

AND

5. Prescribed by or in consultation with an appropriate specialist (e.g. hematologist, oncologist, immunologist, hepatologist, transplant specialist)

AND

6. For Mulpleta, documented trial and failure or contraindication to Doptelet

Immune Thrombocytopenia

Tavalisse:

The plan may authorize **Tavalisse** for patients when **ALL** of the following criteria are met:

1. Documented diagnosis of immune thrombocytopenia

AND

2. The patient is 18 years of age or older

AND

3. Prescribed by or in consultation with an appropriate specialist (e.g., hematologist, oncologist, immunologist, hepatologist, transplant specialist)

AND

4. Documentation of **one (1)** of the following:
    a. Baseline platelet count is less than 30,000/mcL
    b. Medical necessity for platelet evaluation (e.g., upcoming surgery, peptic ulcer disease or condition that may predispose patient to bleeding)

AND

5. Documented insufficient response or contraindication to **ALL** of the following:
    a. Splenectomy
    b. Corticosteroids
    c. Immunoglobulins
    d. Rituxan (rituximab)
    e. Thrombopoietin receptor agonist (i.e., Promacta, Nplate)

Doptelet Tablets:

The plan may authorize **Doptelet tablets** for patients when **ALL** of the following criteria are met:

1. Documented diagnosis of immune thrombocytopenia

AND

2. The patient is 6 years of age or older

AND

3. Prescribed by or in consultation with an appropriate specialist (e.g., hematologist, oncologist, immunologist, hepatologist, transplant specialist)

AND

4. Documentation of **one (1)** of the following:
    a. Baseline platelet count is less than 30,000/mcL
    b. Medical necessity for platelet evaluation (e.g., upcoming surgery, peptic ulcer disease or condition that may predispose patient to bleeding)

AND

5. Documented insufficient response or contraindication to **ALL** of the following:
    a. Splenectomy
    b. Corticosteroids
    c. Immunoglobulins
    d. Rituxan (rituximab)
    e. Thrombopoietin receptor agonist (i.e., Promacta, Nplate)

Doptelet Sprinkle Capsules:

The plan may authorize **Doptelet Sprinkle capsules** for patients when **ALL** of the following criteria are met:

1. Documented diagnosis of immune thrombocytopenia

AND

2. Patient is at least 1 year of age and less than 6 years of age

AND

3. Prescribed by or in consultation with an appropriate specialist (e.g., hematologist, oncologist, immunologist, hepatologist, transplant specialist)

AND

4. Documentation of **one (1)** of the following:
    a. Baseline platelet count is less than 30,000/mcL
    b. Medical necessity for platelet evaluation (e.g., upcoming surgery, peptic ulcer

disease or condition that may predispose patient to bleeding)

AND

5. Documented insufficient response or contraindication to **ALL** of the following:
    a. Splenectomy
    b. Corticosteroids
    c. Immunoglobulins
    d. Rituxan (rituximab)
    e. Thrombopoietin receptor agonist (i.e., Promacta, Nplate)

LIMITATIONS

1. Doptelet tablets and Mulpleta for chronic liver disease will be approved for a duration of one month for a one-time fill.

CODES

None

REFERENCES

1. Doptelet (avatrombopag) [prescribing information]. Durham, NC. Dova Pharmaceuticals, Inc. July 2025.
2. George J, Arnold D. Immune thrombocytopenia (ITP) in adults: Second-line and subsequent therapies. In: Tirnauer J, ed. UpToDate [database online], 2021. www.uptodate.com. Accessed September 30, 2021.
3. George JN, Arnold DM. Immune thrombocytopenia (ITP) in adults: Second-line and subsequent therapies. In: Tirnauer JS, ed. UpToDate [database online], 2021. www.uptodate.com. Accessed September 29, 2021.
4. Mulpleta (lusutrombopag) [prescribing information]. Florham Park, NJ: Shionogi Inc; October 2020.
5. Neunert C, Lim W, Crowther M, et al. The American Society of Hematology 2011 Evidence-based practice guideline for immune thrombocytopenia. Available at: http://www.hematology.org/Practice/Guidelines/2934.aspx. Accessed September 10, 2019.
6. Neunert C, Terrell D, Arnold D, et al. The American Society of Hematology 2019 Evidence-based practice guideline for immune thrombocytopenia. Available at: https://ashpublications.org/bloodadvances/article/3/23/3829/429213/American-Societyof-Hematology-2019-guidelines-for. AccessedNovember 24, 2025.
7. Tavalisse (fostamatinib) [prescribing information]. South San Francisco, CA. Rigel Pharmaceuticals, Inc. August 2024.

APPROVAL HISTORY

September 13, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. August 8, 2023: For Chronic Liver Disease, added provider requirements and a step through Doptelet if the requested medication is Mulpleta. For Immune Thrombocytopenia, added Tavalisse to the Medical Necessity Guideline, removed reauthorization criteria, added additional requirements surrounding prerequisite therapies, and updated baseline platelet count requirements. (effective 11/1/2023).
2. September 10, 2024: No changes.
3. November 4, 2025: Updated age requirement for Doptelet tablet criteria for persistent or chronic immune thrombocytopenia from 18 years of age to 6 years of age or older based on expanded FDA labeling. Administrative update to overview with Doptelet tablet's expanded age indication in patients with persistent or chronic immune thrombocytopenia 6 years of age and older. (effective 12/1/2025)
4. December 9, 2025: Added coverage criteria for Doptelet Sprinkle capsules. Administrative update to overview to clarify approved indications for Doptelet by formulations (effective 2/1/26).

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are

medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.