Clinical Policy: Lusutrombopag (Mulpleta)

Reference Number: CP.PHAR.407
Effective Date: 09.18.18
Last Review Date: 02.24
Line of Business: Commercial, HIM, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Lusutrombopag (Mulpleta®) is a thrombopoietin (TPO) receptor agonist.

FDA Approved Indication(s)

Mulpleta is indicated for the treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure.

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® that Mulpleta is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of chronic liver disease;
2. Prescribed by or in consultation with a hematologist, hepatologist, or gastroenterologist;
3. Age ≥ 18 years;
4. Recent (within the past 14 days) platelet count is < 50 x 10^9/L;
5. Member is scheduled to undergo an invasive medical or dental procedure within the next 30 days;
6. Mulpleta is not prescribed concurrently with another thrombopoietin receptor agonist (e.g., Doptelet®, Nplate®, Promacta®) or spleen tyrosine kinase inhibitor (e.g., Tavalisse™);
7. Dose does not exceed 3 mg per day (1 tablet per day).

Approval duration: 14 days (no more than 7 total days of treatment)

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Thrombocytopenia:

1. Re-authorization is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 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.PA.154 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
TPO: thrombopoietin

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
- Examples of chronic liver disease include: alcoholic liver disease, chronic viral hepatitis (e.g., hepatitis B and C), and nonalcoholic steatohepatitis.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Thrombocytopenia	3 mg PO QD for a total of 7 days Begin dosing 8-14 days prior to a scheduled procedure. Patients should undergo their procedure 2-8 days after the last dose.	3 mg/day

VI. Product Availability
Tablet: 3 mg

VII. References
1. Mulpleta Prescribing Information. Florham Park, NJ: Shionogi, Inc.; April 2020. Available at: https://www.mulpleta.com. Accessed October 11,2023.
2. Kumar A, Mhaskar R, Grossman BJ, et al on behalf of the AABB (American Association of Blood Banks) Platelet Transfusion Guidelines Panel. Platelet transfusion: a systematic review of the clinical evidence. Transfusion. 2015; 55: 1116-1127.
3. Hayashi H, Beppu T, Shirabe K, Maehara Y, and Baba H. Management of thrombocytopenia due to liver cirrhosis: a review. World J Gastroenterol. 2014; 20(10): 2595-2605.
4. Northup PG, Garcia-Pagan JC, Garcia-Tsao G, et al. Vascular liver disorders, portal vein thrombosis, and procedural bleeding in patients with liver disease: 2020 practice guidance by the American Association for the Study of Liver Diseases. Hepatology. 2021;73(1):366-413.
5. Saab S, Bernstein D, Hassanein T, Kugelmas M, Kwo P. Treatment Options for Thrombocytopenia in Patients With Chronic Liver Disease Undergoing a Scheduled Procedure. J Clin Gastroenterol. 2020;54(6):503-511.
6. O'Leary JG, Greenberg CS, Patton HM, Caldwell SH. AGA Clinical Practice Update: Coagulation in Cirrhosis. Gastroenterology. 2019;157(1):34-43.
7. O'Shea RS, Davitkov P, Ko CW, et al. AGA Clinical practice guideline on the management of coagulation disorders in patients with cirrhosis. Gastroenterology. 2021;161(5):1615-1627.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2020 annual review: no significant changes; references reviewed and updated.	11.02.19	02.20

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2021 annual review: added requirement that Mulpleta is not prescribed concurrently with other thrombopoietin receptor agonists; clarified medical or dental procedure should be invasive per clinical trial inclusion criteria; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	11.18.20	02.21
1Q 2022 annual review: no significant changes; references reviewed and updated.	11.15.21	02.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.23.22	
1Q 2023 annual review: no significant changes; references reviewed and updated. Noting that the template verbiage for continued therapy does not apply to thrombocytopenia.	10.31.22	02.23
1Q 2024 annual review: added spleen tyrosine kinase inhibitor (e.g., Tavalisse™) concurrent use exclusion; references reviewed and updated.	11.06.23	02.24

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.