UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1250-9
Program	Prior Authorization/Notification
Medication	Doptelet® (avatrombopag)
P&T Approval Date	8/2018, 8/2019, 8/2020, 8/2021, 1/2022, 1/2023, 1/2024, 1/2025, 9/2025
Effective Date	12/1/2025

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 adult patients with chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment. Doptelet is also indicated for thrombocytopenia in pediatric patients 1 year and older with persistent or chronic immune thrombocytopenia who have had an insufficient response to a previous treatment.

2. Coverage Criteria[a]:

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 12 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.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

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]. Morrisville, NC: AkaRx, Inc.; July 2025.

Program	Prior Authorization/Notification - Doptelet (avatrombopag)
Change Control	
8/2018	New program.
8/2019	Updated background and criteria with new indication in ITP. 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.
1/2023	Annual review with no changes to coverage criteria. Added state mandate.
1/2024	Annual review with no changes to coverage criteria.
1/2025	Annual review. Updated initial authorization for ITP to 12 months. Updated references.
9/2025	Updated background to include pediatric ITP indication with no change to coverage criteria. Updated reference.