

## romiplostim (Nplate)

### Commercial Medical Benefit Drug Policy

For oncology-related indications, medical necessity criteria can be found here: [Blue Shield Oncology-Related Medication Policies](#).

For PPO, Direct Contract HMO, and when applicable, ASO, and Shared Advantage: Please access Evolent's [CarePro Provider Portal](#) to submit your request.

### Place of Service

Infusion Center Administration

Office Administration

Outpatient Facility Infusion Administration

### Drug Details

**USP Category:** BLOOD PRODUCTS AND MODIFIERS

**Mechanism of Action:** thrombopoietin receptor agonist

**HCPCS:**

J2802:Injection, romiplostim, 1 microgram

**How Supplied:**

125 mcg, 250 mcg, 500 mcg (single-use vials)

### Condition(s) listed in policy *(see coverage criteria for details)*

- Primary Immune Thrombocytopenia (ITP)

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

### Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

### Coverage Criteria

The following condition(s) require Prior Authorization/Preservice.

#### Primary Immune Thrombocytopenia (ITP)

Meets medical necessity if all the following are met:

Initial

1. Platelet count is less than 30,000/mcl (i.e.  $<30 \times 10^9/L$ )

2. Not being used in combination with another medication for ITP (e.g., Doptelet, Promacta, Tavalisse, Wayrilz)
3. Inadequate response or intolerable side effect to one of the following treatments: corticosteroids, IVIG, anti-D antibody, or splenectomy, or contraindication to all these treatments cannot be used

#### Reauthorization

1. Platelet count has increased or stabilized from baseline and is less than or equal to 400,000 cells/mcl
2. Not being used in combination with another medication for ITP (e.g., Doptelet, Promacta, Tavalisse, Wayrilz)

#### **Covered Doses:**

Not to exceed 10 mcg/kg given subcutaneously weekly

#### **Coverage Period:**

Initial: 3 months

Reauthorization: One year

#### **ICD-10:**

D69.3

#### **References**

1. AHFS. Available at: [www.lexi.com](http://www.lexi.com)
2. Drugdex. Available at: <http://www.micromedexsolutions.com>
3. Neunert C, Terrell DR, Arnold DM, et al. American Society of Hematology 2019 guidelines for immune thrombocytopenia. *Blood Adv* 2019;3(23):3829-3866.
4. Nplate (romiplostim) Prescribing Information. Amgen, Thousand Oaks, CA. 3/2025.

#### **Review History**

Date of Last Annual Review: 4Q2025

Changes from previous policy version:

- Request to use this drug for oncology-related indications should be directed to Evolent

*Blue Shield of California Medication Policy to Determine Medical Necessity  
Reviewed by P&T Committee*